Health Care Financing Grants and Contracts Reports

Federal Regulations, Statutes, and Reporting Requirements as Barriers to Efficient Medicaid Program Operations

Published by the Health Care Financing Administration
Office of Research, Demonstrations, and Statistics

Health Care Financing Grants and Contracts Reports

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I. INTRODUCTION

A. Project Basis

Since Medicaid began in 1966, program expenditures have grown rapidly: in fiscal year 1980, total Medicaid costs reached an estimated $25.3 billion. This rapid growth has strained federal and state budgets to the point where officials at both levels are concerned about the "Medicaid crisis" and the ability of government to continue to deliver quality health services to recipients.

For a number of years, state Medicaid administrators have claimed that federal requirements have stood in the way of innovative approaches to the delivery of health care services. There are several reasons for this. First, although statutes and regulations attempt to achieve specific policy objectives, they may create unintended and negative consequences. Second, even if legislation does have the desired effect, policy objectives may change; or the circumstances that justified the requirements may change. Third, the volume of regulations and requirements increases administrative complexity. And finally, the interrelationships between federal regulations and the particular delivery characeristics of each state program make it difficult to solve problems through federal regulatory activity.

It has been said that because of the entitlement nature of Medicaid, the program is uncontrollable. However, for state administrators, the Medicaid program is not open-ended in the short run. States must attempt to administer Medicaid within the limitations of federal requirements and a fixed amount of state funds. The state share of the total Medicaid budget is 44 percent; in many states, federal and state financial responsibilities are approximately equal.

Concern about controlling costs arises because costs are high, and because it is not always clear that higher costs mean greater value. Improved efficiency is necessary for any cost control strategy that seeks to avoid reductions in essential program benefits. Federal requirements reduce efficiency to the extent that they hinder states from spending less in areas of least marginal value or spending more in areas of greatest marginal value; or to the extent that they inhibit the timeliness of doing either.

As health care costs grow and consume increasing portions of state government budgets, traditional and essential nonhealth services are affected by the heightened competition for funds. With the loss of general revenue sharing funds, the increase in voter initiatives to limit state spending and tax burdens, and the deterioration of regional economies, states have clear and powerful incentives to control health care spending in both the short and the long run.

The skill and ability of state administrators to operate Medicaid programs have grown with experience. State administrators' commitment to the goal of providing health care services to the poor is strong. State administrators believe that Medicaid is a well-run program, but that federal requirements do not always recognize state concerns and efforts to ensure the efficiency and fiscal integrity of program operations.

This project is based on discussions between state and federal officials; it recognizes important and long-standing concerns of state administrators, who perceive some current federal requirements as barriers to meeting their primary objectives:

- to make the best use of available resources;
- to operate programs efficiently to minimize cutbacks in service or eligibility;
- to manage cutbacks so that the least harm is done to program recipients.

B. Medicaid Overview

Title XIX of the Social Security Act authorizes the Medicaid program. The program is financed from state and federal funds; the federal contribution for medical services provided under the program ranges from 50 to 78 percent. States administer the program within federal guidelines and requirements, and in accordance with a State Plan (a written agreement between the state and the Department of Health and Human Services). The purpose of Title XIX is to enable each state "as far as practicable under the conditions in such state to furnish medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals

whose income and resources are insufficient to meet cost of necessary medical services."* (Emphasis added.)

Medicaid covers individuals eligible to receive cash assistance from welfare programs established under the Social Security Act: Title IV-A, Aid to Families with Dependent Children (AFDC), or Title XVI, the Supplemental Security Income (SSI) program for the aged, blind, and disabled. Under an option allowed when programs for the aged, blind, and disabled were consolidated into the SSI program, some states use their own more strict standards for determining Medicaid eligibility for aged, blind, and disabled individuals. States can choose to cover optional groups, such as individuals in institutions whose income would make them ineligible for cash assistance. States can also choose to cover the medically needy who fit into a category of cash assistance coverage (aged, blind, or disabled persons, or members of families with dependent children with an absent, incapacitated, or unemployed parent) and who do not have enough money to pay for their medical care.

Title XIX requires participating states to provide "mandatory" services to the categorically eligible. When the program began, these services included inpatient hospital, outpatient hospital, laboratory and X-ray, skilled nursing home, and physician services. Subsequent amendments to Title XIX have added home health, family planning, early and periodic screening, diagnosis, and treatment (EPSDT), rural health clinic, and nurse midwife services. States can choose to provide other "optional" services, such as clinic services, prescribed drugs, dental care, eyeglasses, intermediate care facilities, chiropractic services, and other medical or remedial care. Most Medicaid spending occurs for institutional services.

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* Section 1901, Social Security Act.

Table I-A

Medicaid Expenditures by Service, 1979 (in millions)

	Federal	State	Total	Percent
Hospital Care	$ 4,347	$ 3,662	$ 8,009	36.94
Physician Services	1,203	1,015	2,217	10.22
Dental Services	243	205	448	2.07
Other Professional Services	249	210	459	2.12
Drugs	665	560	1,226	5.65
Nursing Home Care	4,775	4,021	8,796	40.57
Other Health Services	287	241	528	2.44
Total	$11,769	$ 9,914	$21,683	

Source: Health Care Financing Review, Summer, 1980

In 1980, an estimated 21.7 million persons were eligible for Medicaid, approximately a 50 percent increase over 1970.

Table I-B

Medicaid Eligibles by Category, 1980 (in thousands)

Aged	3,400
Blind or disabled	2,852
AFDC/adults	5,047
AFDC/under 21	9,248
Non-AFDC children	1,189
	21,735

Source: Administration Budget Proposal, 1980.

Program expenditures increased in the early years of the program as additional states joined. Other increases occurred as states included optional groups of eligibles and optional services in the program, and as Congress added mandatory services. States continued to modify their benefits and coverage groups throughout the 1970s. The majority of changes reported as late as the period from 1978 to mid-1980 were benefit and eligibility increases.* (More recent reports indicate that virtually all expansion has ended, and that many states are actively planning or considering program cutbacks.)

Inflation in health care prices has been another significant factor in increases to Medicaid expenditures in recent years. Increases in total national personal health care expenditures averaged 12.2 percent annually during the period 1965-1979.

Table I-C

Total Federal and State Program Payments, 1971-1980 (in thousands)

Fiscal Year	Payments	Percent Increase
1971	$ 6,345,199	
1972	7,346,131	15.8
1973	8,713,761	18.6
1974	9,737,398	11.7
1975	12,086,166	24.1
1976	13,977,348	15.6
1977	16,354,599	17.0
1978	18,168,000	11.1
1979	20,736,000	14.1
1980	24,133,000	16.4

Source: Data on the Medicaid Program, 1979 Edition; 1978-1980, unpublished data, HCFA.

* National Governors' Association, State Initiatives in Medicaid Cost Containment.

Currently all states except Arizona have Medicaid programs. The District of Columbia, Puerto Rico, Guam, and the Virgin Islands also participate in Medicaid. Ten states account for about two thirds of Medicaid expenditures; they are New York, California, Pennsylvania, Illinois, Michigan, Massachusetts, Texas, Ohio, Wisconsin, and New Jersey.

The Medicaid program is administered at the federal level by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services. HCFA was created in 1977; it consolidated federal Medicare, Medicaid, and quality assurance activities formerly managed by separate bureaus.

C. Previous Cost Control Efforts

States have developed many initiatives to reduce costs by improving operations without reducing covered services or the number of eligibles. These efforts have been well documented.* Six basic strategies to control expenditures are:

- minimizing the use of open-ended or provider-controlled reimbursement;
- minimizing provider and recipient misuse of the program;
- restricting coverage to deliver service in an appropriate but least expensive setting;
- minimizing Medicaid's subsidy of third parties;
- maximizing the purchasing power of the state;
- minimizing eligibility errors.**

Since the early 1970s, Congress has modified the Medicaid program by enacting laws and establishing various program requirements. Significant actions include:

Social Security Amendments of 1972 (P.L. 92-603)

- established a penalty for states not having effective utilization control programs for institutions;

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* National Governors' Association, State Initiatives in Medicaid Cost Containment.

** National Governors' Association, State Guide to Medicaid Cost Containment.

- limited overall reasonable charge levels to the prevailing charge or the 75th percentile of customary charges;

- eliminated requirements that states move toward providing comprehansive care under Medicaid, and eliminated annual maintenance of effort requirements;

- allowed states alternatives to hospital reimbursement based on reasonable cost which differ from Medicare;

- established higher matching rates for design, development, installation and operation of automated claims processing and information retrieval systems;

- required states to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis;

- established a system of professional review of the necessity and quality of services (Professional Standards Review Organizations (PSRO's)):

- required independent professional review in all intermediate care facilities;

- established a penalty for the failure of states to meet EPSDT requirements.

Medicare-Medicaid Anti-Fraud Amendments of 1977 (P.L. 95-142)

- established time standards for processing of clean claims;

- required disclosure of ownership and other financial information by providers;

- created Medicaid fraud control units separate from the single state agency.

Omnibus Reconciliation Act of 1980 (P.L. 96-499)

- amended Medicaid reasonable cost-related reimbursement for intermediate care facilities and skilled care facilities (ICF's and SNF's). Allowed states to establish rates reasonable and adequate to cover costs of an efficiently run facility;

- provided swing bed reimbursement for small rural hospitals;

- allowed differential reimbursement for days spent in a hospital because a suitable discharge placement cannot be made.

Transfer of Assets Amendment of 1980 (P.L. 96-611)

- permitted states to include in eligibility determination the uncompensated value of property disposed of by the individual.

There is some debate about the degree of flexibility given to states under current laws and regulations. However, there is no doubt that the volume of federal requirements is large and growing larger. For example, the Medicaid subchapter of the Code of Federal Regulations (CFR) was 215 pages long in 1979; it contains many cross-references to PSRO, Medicare, and other subchapters of the CFR.

It has been said that apart from management improvements there are only three basic ways to cut costs in Medicaid:

- reduce the number of eligibles;

- eliminate or restrict services covered;

- lower reimbursement levels.

Although each of these approaches may produce some short-term savings, in the long run they may create negative effects such as:

- shifts in costs to other areas of responsibility with less ability to pay;

- postponement of denial of necessary services, resulting in more severe and expensive problems;

- substitution of more expensive services;

- reductions in provider participation leading to severe limitations in access to care;

- delivery of lower-quality care.

Clearly, improvements in efficiency that can be made by restructuring the program and the system of federal controls that shapes the program are preferable to

extensive cutbacks. However, changing federal policies to ensure improved efficiency is no simple task, given the diversity of programs, the varying political constraints, and the differences in staff and financial resources among states.

State and federal communication and understanding are necessary to the development of workable policies. In recent years, such communication has been significant. State Medicaid administrators have been able to express concerns about policy issues to HCFA through the State Medicaid Directors' Association and the Health Care Committee of the National Council of Public Welfare Administrators. However, real differences about the relative degree of state or federal control necessary to program operations continue to exist, contained in the body of statutes and regulations developed over the history of the program.

II. PROJECT OBJECTIVES

The main objective of this study is to identify federal barriers to the effective and efficient operation of the Medicaid program, as perceived by state officials responsible for administering the program. Such barriers may include statutes, regulations, reporting requirements, and administrative processes.

Given the desire of the Reagan administration to give states more flexibility and to reduce increases in the Medicaid budget, the objective becomes, in effect, to develop a state agenda for necessary changes at the federal level. To accomplish this first objective, one must determine:

- which issues state administrators see as problems;
- how widespread these problems are; and
- the statutory or regulatory basis for problem issues.

A secondary objective is to quantify, to the extent possible, the impact of federal barriers on program operations. Because of the time and resource limitations of this study and the substantial number of issues identified as "problems" by states, this effort is limited to a series of examples of the impact certain reform proposals are likely to have.

III. PROJECT METHODOLOGY

A. Project Start-up and First Survey

The project was conducted between February 11, 1981 and May 8, 1981. To obtain information the quickest way possible so that preliminary results could be presented at the annual meeting of the State Medicaid Directors' Association, primary data were collected by a telephone survey of state Medicaid administrators. Timeliness of project results was also of concern because the project occurred simultaneously with congressional debate about the Medicaid program budget. On February 16, project staff sent a letter to all commissioners of Title XIX single state agencies and state Medicaid directors, alerting them to the project. The letter outlined the project, asked for cooperation from states, and described the information that would be requested.

Project staff located and reviewed background material pertinent to the objectives of the study. Sources used were:

- records and files of the Health Care Committee of the National Council of Public Welfare Administrators;
- records and files of the State Medicaid Directors' Association;
- state responses to the recent survey conducted by the National Governors' Association to identify regulatory problems;
- publications of the Health Care Financing Administration, especially Medicaid conference reports.

From this review, a checklist was developed of issues which seemed to be of concern to states.*

States were contacted to determine who would be responding and to schedule a time to conduct the survey. In a follow-up call, states were asked to provide the following information:

- Fifteen issues which state administrators feel are

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* See Appendix A

barriers to efficient and effective Medicaid program operations;

- a ranking of these issues in the order of importance and criticalness to the state agency;
- statutory or regulatory references for each issue;
- descriptions of solutions or proposals to resolve issues, if available;
- positive and negative effects of solutions;
- names and phone numbers of contact persons for specific issues, when possible.

States were also asked:

- if they could provide cost impact studies or could help develop estimates of cost impacts for specific issues;
- if they had copies available of any studies, reports, correspondence, or other documents on the effect of statutes, regulations, or reporting requirements on program operations;
- if issues on the checklist affected their list and their ranking of issues.

Forty-nine states and the District of Columbia participated in the telephone survey. The significance state administrators attributed to the project is reflected by the high degree of response to the survey and the level of staff who responded.

Table III-A

Respondents by Job Title

Number	Title
2	Commissioners of single state agencies
36	Medicaid directors
12	Others (policy section heads, assistants to directors and commissioners, deputy directors, etc.)

The survey produced an extensive list of issues; the majority of respondents identified fifteen or more.

Table III-B

Number of Issues Identified by Each Respondent

Number of Issues (n)	Respondents
$5 \geq n$	2
$10 > n > 5$	14
$15 \geq n \geq 10$	23
$n \geq 15$	11

To analyze the issues, the information was grouped by "issue area": 556 individual state issues were classified into forty-nine issue areas. Each included at least two responses by states. In addition, there were eighty-five miscellaneous issues that were unique and did not fit into the classification scheme, but were nevertheless important. Miscellaneous issues may reflect:

- problems unique to a particular state;
- emerging issues not yet identified by other states;
- variations in the interpretation of federal requirements;
- limitations of the classification scheme.

All issue areas were scored by giving each state issue a score of 16 minus its rank. Thus a number 1 issue received 15 points, a number 7 issue received 9 points, and so on. Additional issues beyond the fifteen requested were given 1 point apiece. When no rank was given, a share of available points was

calculated. Scores in each issue area were summed.*

Although the telephone survey produced a wealth of issues, it did not produce any reports with cost estimates of federal statutory or regulatory requirements. Respondents provided material such as written confirmation of their comments, copies of waiver proposals, letters to the Department of Health and Human Services about regulations, proposals for state management improvements and recommendations to state legislatures, and general descriptions of medical expenditures.

There may be several reasons for the lack of cost impact reports on federal requirements:

- States attempt to operate programs within the context of existing regulations. Studies of the cost impact of existing regulations would be of low priority, because the state has no control over regulations. One Medicaid director said that such reports would be "academic at best."

- Studies of the cost impact of regulations in any field can be difficult to accomplish; results can be highly inexact. For example, a recent GAO report, Analysis of Proposed New Standards for Nursing Homes Participating in Medicare and Medicaid, examined reasons for a difference of $455 million between industry and HHS estimates of the cost of complying with proposed nursing home regulations. The incremental cost of regulations (the difference in cost between what is required and what would have been done anyway) is particularly difficult to assess.

- States may have information that is informal, or in working documents which they did not believe were appropriate to distribute.

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* Table III-C lists issues identified in the first survey, ranked by the number of states identifying each issue. Table III-D provides a brief description of state concerns about each issue. Appendix C contains regulatory and statutory citations identified in the first survey.

Table III-C

List of Issues and Scores, First Survey

Number States	Issue Area Scores	
38	332	1. EPSDT
37	435	2. Free Choice of Provider
36	407.5	3. Hospital Reimbursement
32	369	4. Nursing Home Reimbursement
31	308	5. Co-Payments
26	217.5	6. Amount, Duration and Scope/Comparability
24	282	7. Physician Reimbursement
24	203.5	8. Sterilization and Hysterectomy Requirements
21	152	9. Quality Control
17	188.5	10. Mandatory and Optional Services
17	168	11. LTC Utilization Control (Physician)
17	146	12. Institutional Bias
16	153.5	13. PSRO's
14	131	14. Utilization Control in Nursing Homes (General)
12	128.5	15. Health Maintenance Organizations
12	96.5	16. Third-Party Liability
12	92.5	17. Statewideness
11	103.5	18. Spenddown
11	100	19. Eligibility Complexity
11	95	20. Family Supplementation
11	91	21. Institutions for Mental Disease (IMD's)
10	77	22. Eligibility Extensions
10	65	23. State Plan Responsiveness
10	59	24. State Assessments and Reviews
7	64	25. Recipient Suspension
6	50	26. Medicaid/Medicare Coordination (SNF)
6	42	27. Notice of Changes in Reimbursement Levels
6	38	28. Eligibility Grandfathering
6	23.5	29. Reporting Requirements
5	53	30. Provider Participation
5	41	31. Duration of SNF and ICF Agreements
5	28	32. Assurance of Transportation
4	37	33. ICF-MR
4	34.5	34. Claims Payment
4	33	35. Medical Care Advisory Committee
4	25	36. Home Health
4	22	37. Limitations on Medicaid Coverage of Part B Services
3	30	38. Indian Health Services
3	28	39. Residency Requirements
3	25	40. Advance Planning Requirements
3	22	41. Incentives for Recipients
3	17	42. Medicaid--IV-D Coordination
3	14	43. Maximum Allowable Cost
2	26	44. Institutionalized Individuals--Start Date for FFP
2	22	45. Definition of Medical Necessity
2	18	46. Rural Health Clinic Reimbursement
2	14	47. EOMB (Utilization Control)
2	12	48. Rate of FFP
2	2	49. Chiropractic Services

N=556

Table III - D

Issues Identified by States as
Barriers to Efficient Medicaid Program Operations

1) EPSDT. Regulations place heavy emphasis on administrative processes to the detriment of the goal of delivering health services. The penalty distorts the program goals and increases a state's risk for serving difficult to reach clients. The program operates without consideration of existing, effective health delivery systems and the unique needs of different areas.

2) Free Choice of Providers. States must allow recipients to obtain services from any qualified Medicaid provider, irrespective of the cost of those services. This restricts a state's ability to purchase quality services available at relatively lower costs ("the prudent buyer").

3) Hospital Reimbursement. States want greater freedom to develop rate methodologies as alternatives to the Medicare reasonable cost reimbursement approach.

4) Nursing Home Reimbursement. States want early implementation of full effective authority to make payments "reasonable and adequate to meet the costs of efficiently and economically operated facilities" as specified in the Omnibus Reconciliation Act of 1980 (P.L. 96-499).

5) Co-Payments. Co-payments cannot be imposed on mandatory services for the categorically needy. Maximum allowable co-payments are low. These requirements are restrictive and do not allow use of a co-payment system which can effectively modify the use of certain services and settings.

6) Amount, Duration, and Scope/Comparability. States cannot limit services based on diagnosis, illness, or condition, and must make service equal in amount, duration, and scope for all recipients within the group (categorically needy or medically needy). This limits the states' ability to target services and to establish norms for service on which payment can be based.

7) Physician Reimbursement. Reimbursement cannot exceed the Medicare payment level. This restricts state flexibility to develop innovative alternatives and continues disparities between urban and rural fee schedules. States need greater flexibility to pay physicians to manage health care, to share savings for cost effective treatment plans, and to arrange capitation systems.

8) Sterilization and Hysterectomy Requirements. Before a hysterectomy can be performed, a written acknowledgement is required that the individual was informed that the procedure will make the individual incapable of reproducing. There are no exceptions to the requirement. Sterilization consent forms are repetitious and too detailed. The complexity of these requirements is administratively burdensome and causes problems with providers.

9) Quality Control. Medicaid quality control systems are designed to reduce erroneous expenditures by monitoring eligibility determinations, third party liability activities, and claims processing. States support the concept of quality control but have problems with the way it has been implemented. Concerns are: the cost-effectiveness of pursuing certain cases; the use of sanctions, which forces management to focus on avoiding errors rather than on managing the entire program; and the fairness of the regression formula.

10) Mandatory and Optional Services. The current categorization of services as "mandatory" or "optional" makes little sense. There is no medical or economic priority of mandatory over optional services (e.g., rural health vs. ICF). The distinction leads to cutbacks in vital optional services while mandatory services cannot be controlled. States need greater latitude in defining the array of available services.

11) Long-Term Care (LTC) Utilization Control: Physician Responsibilities. A physician must certify and recertify the need for ICF or SNF services for each recipient. This must be done at the time of admission and every sixty days thereafter. This requirement is applied inflexibly, wastes physician time, and has created a system of paper compliance. Plan of Care. The attending physician must establish a written plan of care for each recipient. This must be reviewed every sixty days for SNF services and every ninety days for ICF services.

12) Institutional Bias. In states not covering the medically needy, persons can be eligible for nursing home care without being eligible for community care. SSI payments alone are not sufficient to pay for community care. Alternatives to institutionalization are not well developed or available, in part because of medical necessity requirements. States cannot control private pay patients who enter nursing homes and rapidly deplete resources, thus becoming eligible for Medicaid institutional services. Medicaid needs redirection away from expensive institutionalization.

13) PSRO's. The process of reviewing services is valuable. However, PSRO's do not have fiscal responsibility for their decisions, and very often they simply have replaced successful state utilization control programs. States have strong doubts about the delegation of reviews to hospitals. State would like to have the PSRO's flexibility to do focused reviews.

14) Utilization Control in Nursing Homes. There are many specific requirements for utilization control for ICF and SNF services. These are difficult to manage and coordinate, particularly with respect to the various time frames established for different requirements. States would prefer to have flexibility in utilization control; states should be able to use focused reviews which base review schedules and effort on categorization of nursing home quality. Quarterly showing and validation review requirements increase complexity for states, without corresponding benefits.

15) Health Maintenance Organizations. HMO's cannot be used as effectively as possible in Medicaid because of the 50% Medicare/Medicaid enrollment mix requirements, the freedom of choice requirement, and other overregulation. Cost-effective inducements to participation (extensions of eligibility and sharing of savings) should be allowed.

16) Third Party Liability. The Medicaid program is not an insurance program, and should not be considered an open-ended resource for other federal programs. Insurance coverage and other benefits should not be allowed to restrict coverage if Medicaid coverage is available. Medicaid TPL activities need improvement by establishing a cost-effectiveness threshold for pursuit of TPL and requiring Social Security Administration to capture TPL information and require assignment of benefits.

17) Statewideness. States are required to make all covered services available throughout the state. This precludes targeting services at specified areas of need (such as concentrations of the aged or refugees) or the use of different types of providers to deliver the same health care service in different parts of the state.

18) Spenddown. The spenddown system in medically needy programs needs simplification. Existing problems include determining what medical expenses are covered; ranking incurred expenses in order of priority; and determining levels of protected income, budgeting periods, and system rewards for incurring but not paying bills. Administrative costs and quality control problems are significant because of complexity. Determining personal needs allowance for institutionalized recipients is equally complex.

19) Eligibility Complexity. In general, Medicaid eligibility policies are too complex. The attempt to make Medicaid eligibility policies comparable to cash assistance policies gives rise to significant problems.

20) Family Supplementation. Policies need to be developed to allow reasonable support of institutionalized family members. Lack of supplementation encourages institutionalization and increases Medicaid long-term care costs. Supplementation is now effectively prohibited because of SSI policy and court decisions, despite state laws about family support.

21) Institutions for Mental Disease (IMD's). Medicaid does not cover services to individuals under age 65 in IMD's, or inpatient psychiatric services for recipients over age 21. States have been denied federal financial participation for nursing home services because of reclassification of some facilities as IMD's. Such reclassification is medically unfounded, arbitrary, without benefit of formal rule-making, and contrary to congressional intent.

22) Eligibility Extensions. Three-month retroactive and four-month continued. These extensions of eligibility are difficult to administer. Retroactive coverage does not provide additional health care; it simply pays bills. Post coverage encourages overutilization; it should be at the option of the state.

23) State Plan Responsiveness. The State Plan is a written agreement by which the Medicaid agency agrees to administer or supervise the program according to federal requirements. Changes to the State Plan must be approved by the regional office of HHS. Federal failure to respond promptly to proposed changes in State Plans severely hampers a state's ability to manage the program and to implement cost containment measures.

24) State Assessments and Reviews. Federal officials conduct many reviews of state program operations. These reviews include state assessments, quality control reviews, Medical Management Information Systems (MMIS) certification and system performance reviews, and validation reviews. Contents of these reviews often overlap. Reviews are time-consuming for state staff, but rarely produce useful results. There is a lack of good, knowledgeable, practical technical assistance.

25) Recipient Suspension. Recipients who abuse the program (by repeated violations of lock-in) or who are convicted of fraud in state courts can receive medical assistance if they continue to meet eligibility requirements. States need authority to terminate services to abusive recipients.

26) Medicaid/Medicare Coordination - SNF. Nursing homes can participate in Title XVIII and/or Title XIX, but there is no requirement that they participate in both. Some policies are interpreted differently between programs; this causes costs and responsibilities to be shifted from Medicare to Medicaid. Improved coordination is necessary, including required participation in both programs.

27) Notice of Changes in Method or Level of Reimbursement. States must provide public notice of proposed changes in the method or level of reimbursement for a service if that change affects Medicaid payments for the service by one percent or more. Notice must be given sixty days before the change. This limits states' ability to make timely changes and duplicates requirements of state administrative procedure acts.

28) Eligibility Grandfathering. Many grandfathered groups increase administrative complexity and quality control problems, and make program coverage difficult to justify to excluded groups. Consolidation and reduction of grandfathered groups is necessary.

29) Reporting Requirements. There is poor coordination among existing required federal reports. Data are difficult to compare because of terminology problems (the 25 series of quarterly estimates vs. the 64 series of actual expenditures). Some reports are redundant (yearly totals) and others unnecessary (the quarterly showing for long-term care utilization control).

30) Provider Participation - Bed Restrictions. A state health planning agency is responsible for approving expenditures for construction and changes in numbers of beds through the certificate of need processes. Federal financial participation (FFP) is not available for capital expenditures unless approval is given. However, states' planning agencies can approve increases in the total number of beds, irrespective of the ability of the state Medicaid agency to pay for them. States need greater ability to limit the total number of beds they will support under Medicaid.

31) Duration of SNF and ICF Agreements. Agreements cannot exceed twelve months, irrespective of the quality of the facility. This forces an unnecessarily high level of survey and certification activities. Federal financial participation is allowed for up to thirty days after an agreement expires or terminates. Because of difficulties in transferring patients from large facilities and the provider's right to appeal, recipients are in those facilities after federal financial participation is no longer available after a termination. States need flexibility to establish the duration of agreements and termination periods.

32) Assurance of Transportation. States are required to ensure necessary transportation to and from providers of Title XIX services. This requirement is difficult to put into practice and should be either modified to allow more flexibility, or eliminated.

33) Intermediate Care Facilities for the Mentally Retarded (ICF-MR). Standards and requirements for ICF-MR are overly rigid and raise costs unnecessarily, particularly in small facilities. The program needs reorientation away from a medical model and toward a development model.

34) Claims Payment. States need flexibility to use various claims payment procedures, including options for periodic interim payments. Timely payment of claims should be liberalized in those cases.

35) Medical Care Advisory Committee. MCAC's increase administrative costs and can slow a state's ability to implement changes. States deal with a variety of provider groups, associations, and the public. The MCAC contributes no more than what can be gained from other contacts.

36) Home Health. Requirements for home health services are overly restrictive. Bi-weekly nurse supervision causes poor utilization of nurses.

37) Limitations on Medicaid Coverage of Medicare Part B Services. States must pay the Medicare coinsurance and deductible for Medicaid eligibles who are covered under a buy-in agreement. This requires states to pay for noncovered services. Medicaid responsibility should extend only to covered services; other costs should be assumed by Medicare.

38) Indian Health Services. States are used to process and pay claims of Indian Health Services facilities. The program is 100% federally funded. The state has no control over rates. Payment goes to the Bureau of Indian Affairs, not the individual facilities. The program increases state administrative responsibility and complexity. If a cap is enacted, states will be penalized as IHS billing increases.

39) Residency Requirements. Statement of intent to reside is subjective and difficult to administer for nursing home residents. Interstate agreements for conflict resolution and extensive record keeping are required. States would like to return to the previous set of regulations on this issue.

40) Advance Planning Requirements. Requirements for the purchase of computer hardware or software severely constrain a state's ability to develop and purchase new systems.

41) Incentives for Recipients. States need the ability to encourage recipients to be prudent consumers of care by sharing benefits of reduced costs with them. This could be done by extending eligibility or by increasing cash benefits.

42) Medicaid-IV-D Coordination. Cooperation between Title XIX and Title IV-D (Child Support) should be improved. Present regulations allow a cooperative agreement between the IV-D agency and the state Medicaid agency to secure and enforce medical support obligations. Regulations should require the IV-D agency to pursue medical support obligations to the extent such efforts are cost effective.

43) Maximum Allowable Cost. Maximum allowable costs for pharmacy services have not always enabled states to control costs. The requirement has caused problems with nursing home providers whose administrative responsibilities are increased because of MAC. Simpler, cost-effective systems should be allowable.

44) Coverage of Institutionalized Individuals - Start Date for Federal Financial Participation. For individuals eligible for cash assistance if they were not institutionalized, federal regulatory interpretation allows federal financial participation only starting with

the first full calendar month of institutionalization. This increases state costs. Coverage should be allowed from the date of institutionalization.

45) Definition of Medical Necessity. States can place limits on services based on medical necessity and utilization control. Confusion about medical necessity has weakened a state's ability to manage the program. Court reliance on private provider interpretations has resulted in many benefit expansions. States need greater authority to define medical necessity.

46) Rural Health Clinic Reimbursement. Payment is based on reasonable cost. There is significant variance between rural health clinic visit rates and UCR rates to physicians for similar services. States want greater flexibility to establish rural health clinic rates.

47) Explanation of Medical Benefits (EOMB). (Utilization Control). States are required to mail an Explanation of Benefits to a sample of recipients. This is not cost effective; states should focus on other methods to detect fraud and abuse.

48) Rate of Federal Financial Participation. The rate of financial participation should reflect the unemployment rate and other economic conditions in a state.

49) Chiropractic Services. Treatment services are allowable under the program but diagnositc services are not. Diagnostic services should be reimbursable.

B. Quantitative Estimates and Second Survey

Project staff met with the HCFA project officer and other HCFA staff on March 24, 1981, to review the list of issues and select issues for which cost estimates could be developed. The original research design proposed the development of estimates using methodologies found in state reports. Given the time limits of the study and the lack of reports with cost estimate methodologies, this effort was modified to develop examples of cost impacts of certain reforms on various states. Issue selection was based on:

- the availability of relatively clear-cut solutions suggested by a state;
- the availability of state resources to develop cost estimates;
- the overall ranking of the issue in the first survey.

Issues selected for cost analysis were:

Free Choice of Providers

Hospital Reimbursement

Co-Payments

PSRO's

Service Targeting.*

The project conducted a second survey to validate the first survey rankings, to supply states with a full list of issues on which to comment, and to determine the extent of state concerns. It was agreed that the re-survey of all states would substitute for additional telephone interviews with a few states, as orginally proposed in the project. A list and a description of the forty-nine issues were sent to all the first survey respondents. They were asked to select from the list of issues:

- five "most significant" barriers to Medicaid program operations,

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* Appendix D contains the material sent to states for the development of cost estimates.

- five "next-most significant" barriers,

- issues not applicable or not a barrier.

In addition, states were asked to provide any comments on the issues.

The response rate for the second survey was 74 percent; thirty-seven states responded.* States approved the effort to articulate consensus positions on issues. Several states commented that all the issues seemed important, and they hoped all would be pursued. States pointed out the difficulty of selecting ten issues, given the interrelatedness of many of the issues. Suggested groups of related issues included:**

Reimbursement/Payment

(3) hospital reimbursement, (4) nursing home reimbursement, (7) physician reimbursement, (34) claims payment, and (46) rural health clinic reimbursement.

Eligibility

(18) spenddown, (19) eligibility complexity, (20) family supplementation, (22) eligibility extensions, (28) eligibility grandfathering.

Institutional Bias

(12) institutional bias, (20) family supplementation, and (36) home health.

Service Targeting

(6) amount, duration, and scope/comparability, (10) mandatory/optional, and (12) statewideness.

Process Orientation

(1) EPSDT, (8) sterilization requirements, and (14) utilization control in nursing homes.

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*Table III-E displays the responses of each state in the second survey. Table III-F summarizes the results of the second survey, by issue.

**( ) identifies the issue rank from the first survey, Table III-D.

Table III - E
Responses by State, by Issue, Second Survey

State \ Issue	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	
Alabama																																																		Alabama
Alaska																																																		Alaska
Arkansas		A	A	A	B	A	B			B		A					B		B																			C									C	C	C	Arkansas
California		A	A	A		B	C					A	A		B		B	B		C															C		C	C						C	C				C	California
Colorado																																																		Colorado
Connecticut	A	C	A		B				A	B			A						B		A							B						B				C	C							C			C	Connecticut
Delaware	A	A		A	A					B									B	A		B										B									B							B		Delaware
D.C.	A		A																					A								A										A								D.C.
Florida		A	A	A	B	A	B			B		B					A	C					B															C											C	Florida
Georgia		A		A	A	B														B		A	B																											Georgia
Hawaii	B	A	B	A			B		A				C			B			B		C														C			C	C								C	C	C	Hawaii
Idaho		B	A							B		A			A	C			A	B				B					B				A		C															Idaho
Illinois	B	B	A									A	C		A			A	B		B								B						C			C			A							B	C	Illinois
Indiana	A	B	A	C			A		B	B				C		C	C		B					A	C				A				B																	Indiana
Iowa																																																		Iowa
Kansas			A						A				A					B		B	A	A	B			B			B						C	C			C											Kansas
Kentucky	B	A	A		B	A						B	C		C		A			B										A		B			C			C											C	Kentucky
Louisiana																																																		Louisiana
Maine	A	B	B	A		A			B		B							B	A																										A					Maine
Maryland	B	A	C		A	A				B		B	A		A			B		B																		C					C			C			C	Maryland
Massachusetts																																																		Massachusetts
Michigan	B	A	A			A	A			B		B	B	C			B				A										A	C		C									C					A	C	Michigan
Minnesota		A		C					B			C		B	C	A	C		B					B				B																C	A					Minnesota
Mississippi	B	A	A		A	A						B							B	A			B	B																										Mississippi
Missouri		B	B	B			B						A						A		A				A			A	B									C										C		Missouri
Montana	B	A	A	A	B					B			A					B	B																															Montana
Nebraska		A	B		C		A	B			B	A			C	C	C						C		A	B				C						B	C		C	C		C	A			C		C		Nebraska
Nevada		B	A	A	A					B		A			C		C	C	C	A	B	B	C		C	C		C		B				C	C	C			C		C		C		C		C	C		Nevada
New Hampshire	A	A	A			A				A			C				C	B			B	B	C								C	B			B			C											C	New Hampshire
New Jersey	B	A	A		B	A			B	A							A		B	B																		C								C		C		New Jersey
New Mexico																																																		New Mexico
New York	A	B	B	B		B							A		A							B				A					C		A												C				C	New York
North Carolina		A	A			A	B										A		B								B					B	B					C												North Carolina
North Dakota																																																		North Dakota
Ohio	B	A	A	B							A	A		A			B							B		C					B							C		C							C		C	Ohio
Oklahoma	C	C			C		C	B	A		C		C		C	B	C		A	C		B		A	C	C			A	C		B	A	B	C	C	C	C	C		C	C			C		C	C	C	Oklahoma
Oregon																																																		Oregon
Pennsylvania		A	A		B	A	B			B					C												A		B		C	B	C					C					C		A					Pennsylvania
Rhode Island																																																		Rhode Island
South Carolina	B	A	A	A		A			B	B							A													B			B					C										C		South Carolina
South Dakota																																																		South Dakota
Tennessee																																																		Tennessee
Texas																																																		Texas
Utah		A			A	B			B		B		C		B	B	C	C	C	A	A	A					C																							Utah
Vermont	A	A	A	B	B	B						A	C	C	C		A			C	C		C	B	C		B			C	C				C	C		C			C								C	Vermont
Virginia	A				B	B					A			A	C		C	A	A					B	C	C				B		B		C	C			C											C	Virginia
Washington		A	A	B		A				A	A	A								B	B	C				B		C		C			C				C	C	C	C		C	C	C		C	C	C	C	Washington
West Virginia	A				B			B	B	A	A			A															A		B								A						B				C	West Virginia
Wisconsin	A		A	A		A	B			A				B	B		B									B																								Wisconsin
Wyoming																																																		Wyoming

A Most significant barriers to efficient Medicaid program operations in the state.

B Next most significant barriers.

C Issues that are *not* applicable or *not* a barrier in the state.

Refer to Table III-D for Issue Descriptions.

Table III-F

Summary of Responses by State, by Issue, Second Survey

A	B	C		
11	10	0	1.	EPSDT
21	8	2	2.	Free Choice of Providers
22	6	1	3.	Hospital Reimbursement
11	5	2	4.	Nursing Home Reimbursement
6	10	2	5.	Co-Payments
13	7	0	6.	Amount, Duration and Scope/Comparability
4	6	2	7.	Physician Reimbursement
0	3	0	8.	Sterilization and Hysterectomy Requirements
4	7	0	9.	Quality Control
5	12	0	10.	Mandatory and Optional Services
4	3	1	11.	LTC Utilization Control (Physician)
9	5	1	12.	Institutional Bias
7	1	7	13.	PSRO's
3	2	3	14.	Utilization Control in Nursing Homes
4	3	8	15.	Health Maintenance Organizations
1	3	3	16.	Third-Party Liability
5	6	7	17.	Statewideness
2	6	3	18.	Spend-down
6	10	2	19.	Eligibility Complexity
4	7	3	20.	Family Supplementation
5	4	2	21.	Institutions for Mental Disease
3	5	1	22.	Eligibility Extensions
0	4	4	23.	State Plan Responsiveness
3	6	0	24.	State Assessments and Reviews
2	0	5	25.	Recipient Suspension
1	4	4	26.	Medicaid/Medicare Coordination/SNF
2	1	1	27.	Notice of Changes in Reimbursement Levels
1	2	2	28.	Eligibility Grandfathering
3	5	0	29.	Reporting Requirements
1	4	4	30.	Provider Participation
1	2	4	31.	Duration of SNF and ICF Agreements
2	6	1	32.	Assurance of Transportation
4	2	2	33.	ICF-MR
0	2	3	34.	Claims Payment
0	1	10	35.	Medical Care Advisory Committee
0	1	4	36.	Home Health
0	0	4	37.	Limitations on Medicaid Coverage of Part B Services
0	0	19	38.	Indian Health Services
1	0	7	39.	Residency Requirements
0	0	3	40.	Advance Planning Requirements
1	1	3	41.	Incentives for Recipients
1	0	3	42.	Medicaid-IV-D Coordination
1	0	5	43.	Maximum Allowable Cost
1	0	3	44.	Institutionalized Individuals-Start Date for FFP
3	1	4	45.	Definition of Medical Necessity
0	0	5	46.	Rural Health Clinic Reimbursement
0	0	6	47.	EOMB
1	2	9	48.	Rate of FFP
0	0	17	49.	Chiropractic Services

N = 37

A - Most significant barriers to efficient Medicaid program operations in the state.
B - Next most significant barriers.
C - Issues that are not applicable or not a barrier in the state.

Refer to Table III-D for Issue Descriptions.

Utilization Control in Nursing Homes

(11) LTC utilization control (physician responsibilities), and (14) utilization control in nursing homes (general).

Other state comments suggested emphasizing that:

- Medicaid is not an insurance program; it should not be used as an open-ended resource for other federal programs, such as Medicare or Title V.

- States need to be able to establish limits to the program based on the availability of funds.

- Existing limitations on the responsibility of relatives encourage institutionalization and increase costs.

Second survey results can be used to indicate how widespread certain problems are by examining how many states felt the issue was not a barrier or a problem in the state. However, caution must be used because states were allowed to indicate only ten priority issues; thus any issue not given an "A" or "B" may still be a concern of a state. Issues which appear to be of less widespread concern include the Medical Care Advisory Committee, Indian Health Services, the rate of FFP, and chiropractic services. This does not mean that the intensity of concern has diminished in any of the states identifying these issues in the first survey.

PSRO's, HMO's, and statewideness were each identified as high priorities by a number of states, and as not being barriers in approximately an equal number of states. Issues that shifted downward in priority included sterilization requirements and third-party resources. This appears to reflect the higher ranking in the second survey of issues with greater fiscal impact and broader definition.

Several issues which were ranked relatively low in the first survey stand out because of the number of states identifying them as significant barriers in the second survey. These issues include requirements for assurance of transportation, standards for intermediate care facilities for the mentally retarded, and the definition of medical necessity.

Noteworthy in the second survey results are the issues

that no states identified as not being barriers to efficient operations. This group consists largely of issues states consider to be administrative irritants: EPSDT, sterilization requirements, quality control, state assessments and reviews, and reporting requirements. Although they are not ranked as high as major fiscal impact issues, there is clearly widespread agreement among states that these requirements are inefficient and consume disproportionate amounts of staff time.

C. Presentation at State Medicaid Directors' Annual Meeting

The final stage in the identification of barriers to efficient state Medicaid program operations was the presentation of preliminary findings on April 14, 1981, at the annual meeting. A working draft of the report was made available, and the attending directors were given an opportunity to provide written comments on various major issues. Although the written and oral response to the presentation was limited, the comments indicated basic agreement with study findings by state officials.

The overriding concern expressed at the meeting was the imposition of a federal cap on Medicaid spending. The official announcement that the Reagan administration would seek to impose a cap was made in the middle of February, as the study began. State perceptions about the likeliness of a cap bear on the objectives and use of this study in a number of ways:

- The priority of state issues appears to have shifted somewhat over the course of the study to focus on the high fiscal impact items.

- States expressed concern that events in the budget process were moving too quickly to make states' input on issues consequential.

- States felt that efforts to grant more flexibility should be expedited so that flexibility would be available to manage expected cutbacks.

- States preferred permanent statutory changes to a waiver approach in establishing program flexibility.

Although the need for prompt statutory change was recognized, there was also some fear that the use of the reconciliation process to make program changes each year might increase the complexity of the program because of

the number of changes possible, the increased regulatory workload for HCFA, and the difficulty of implementing changes quickly under uncertain conditions.

Based on the number of states identifying individual issues, the following ranked high in the first or second surveys, and can be classified as major concerns of states:

- Free choice of provider
- Hospital reimbursement
- Nursing home reimbursement
- Physician reimbursement
- Amount, duration, and scope/comparability
- Mandatory and optional services
- Statewideness
- EPSDT
- Utilization control in long-term care facilities
- Co-payments
- PSRO's
- Quality control
- Sterilization requirements
- Eligibility complexity
- HMO's.

IV. PROJECT FINDINGS

A. Analysis of Major Issues

Free Choice

Section 1902(a)(23) of the Social Security Act provides that recipients may obtain Medicaid services from any qualified provider who undertakes to provide services. This "free choice" provision is implemented by 42 CFR 431.51.

The "free choice" provision was established by Congress to guarantee that Medicaid patients would be treated in the mainstream of medicine and not be segregated into a second-class system of health care.

The "free choice" requirement has restricted the ability of states to purchase quality services that may be available at relatively lower costs. The General Accounting Office report Savings Available by Contracting for Medicaid Supplies and Laboratory Services concluded that substantial savings could be made through competitive purchase of laboratory and other services, and recommended amending the Social Security Act to eliminate barriers imposed by the free choice provisions.

States have identified many problems associated with free choice:

- States cannot make the best use of limited state and federal resources by implementing a prudent-buyer approach to the purchase of health services. In 1975, New York City attempted to advertise for bids in order to select a single laboratory in each borough to provide services for recipients, but the effort was blocked because of the free choice provision.

- Recipients lose the effect of having a continuing-care provider, because they can shop around and receive multiple services from various providers. Overuse of services increases costs and makes treatment plans less effective.

- Market incentives for efficient physician and institutional providers are limited. This is significant, because states must purchase services from providers with wide variances in costs (particularly hospitals).

Thirty-seven states identified free choice as a barrier in the first survey, and it was the highest-ranked issue in the second survey. Several states felt that free choice was not a problem, or that there was some risk of relegating the poor to a second-class system if the provision was dropped. Other states pointed out that many systems have been developed to ensure that quality care is available under Medicaid, and that a provider's right to participate in the program irrespective of costs weakens a state's ability to negotiate payment rates.

States have suggested several options for cost-effective service delivery if existing free choice provisions are removed or modified:

- Allow free choice at the time of eligibility certification, but restrict coverage to the provider chosen.

- Restrict the use of providers whose costs are excessive. One state indicated that hospital rates in a large city varied by as much as 150 dollars per day, and that the state had no way to induce recipients to make cost-conscious decisions.

A provision to limit freedom of choice was introduced and subsequently dropped from the omnibus reconciliation bill of 1980. This provision would have limited freedom of choice, but required that any limitations be cost-effective and that reasonable access to services be maintained.

States place the highest priority on removal or modification of the free choice requirement, so that a Medicaid agency can act as a prudent buyer of services.

Hospital Reimbursement

Section 1902(a)(13)(D) of the Social Security Act requires states to pay the reasonable cost of inpatient hospital services. The law also says that a state's methods and standards for determining reasonable cost must be reviewed and approved by the secretary of HHS. The intent of the reasonable cost requirement is to avoid the subsidization of Title XIX recipients by hospitals or private-pay patients and to ensure an adequate supply of hospital beds for Medicaid purposes.

The requirement for hospital reimbursement is implemented by 42 CFR 447.261. This regulation requires a state to

adopt Medicare standards for determining reasonable cost. As an alternative, a state may instead adopt standards which:

- provide incentives for economy,
- provide for rates no higher than rates determined using Medicare standards,
- ensure adequate participation of hospitals,
- afford opportunities for administrative review, and
- provide for adequate documentation.

In principle, states do have some freedom to develop their own reimbursement systems; but to date only twelve states have done so. A number of states want greater freedom to develop alternatives to the Medicare reasonable-cost approach.

States believe that the current option to develop alternative reimbursement systems has limitations and does not grant sufficient flexibility. Idaho, New York, Michigan, and Wisconsin have approved alternatives; in the second survey, however, all four indicated that hospital reimbursement was a barrier. Several states viewed the amount of work and time necessary for approval of an alternative system as a barrier. Missouri estimated that it would take approximately two years for the state to implement an alternative plan.

States ranked hospital reimbursement requirements as major barriers in both the first and second survey. Only one state indicated that hospital reimbursement requirements were not a problem. New Hampshire said that states should be able to set rates based on costs necessary for an efficiently and economically run facility, as allowed for nursing home reimbursement under the Omnibus Reconciliation Act. North Carolina noted that states cannot make adjustments in reimbursement rates based on budgetary constraints. Several states indicated that they believed the problem of increasing hospital expenditures could not be dealt with effectively without some restrictions on the total number of beds that states would support through Medicaid.

The major point raised by states was the relationship to Medicare hospital services purchasing. One state administrator said that it was "time to get off the Medicare

merry-go-round." States feel constrained by the use of Medicare reimbursement principles. A related problem is that Medicaid has a relatively small share of the hospital market compared to Medicare; per year, Medicare spends approximately four times as much as Medicaid on hospital care. Given general increases in hospital expenditures caused by inflation, technology changes, and actions of all third-party payers, Medicaid can do little by itself to control hospital costs.

The Congressional Budget Office has noted that savings of up to $250 million might be available in 1982 if states were able to reduce reimbursement rates. States could choose to set rates lower than current reasonable costs but high enough to persuade hospitals to participate to meet Medicaid needs; or they could choose to negotiate with hospitals to set rates. These options could create market-like pressures on hospitals and lead to greater efficiency and lower costs. However, it is also possible that costs would shift to other payers, or that access to care could be reduced because of nonparticipation by hospitals.

Nursing Home Reimbursement

Expenditures for nursing home services have accounted for almost half of Medicaid costs in recent years. Nursing home costs have also increased more rapidly than other Medicaid costs. One likely reason is that nursing homes have been paid on a cost-related basis that gives them little incentive for efficiency. Cost-related reimbursement policies may also have encouraged nursing home expansion by allowing providers to pass through interest expenses or by allowing generous reimbursement for capital costs.

This cost-related policy was included in Title XIX by Section 249 of the Social Security Amendments of 1972. The regulations that implemented this portion of the law are found in 42 CFR 447.272-447.311; they cover cost finding and reporting, audits, payment determination, and payment assurances. The regulations require nursing home payment rates to be "adequate to reimburse in full the actual allowable costs of a facility that is economically and efficiently operated."

States may appear to have been permitted a fair measure of flexibility in determining rates under these policies. In practice, states have felt themselves to be constrained, partly because there has been much litigation over the adequacy of reimbursement rates.

The requirement that nursing homes be reimbursed on a reasonable cost-related basis has been deleted by Section 962 of the Omnibus Reconciliation Act of 1980. The law now requires states to reimburse nursing home services at rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities in order to provide care in conformity with state and federal laws, regulations, and standards. The secretary of HHS retains final authority to review the rates developed by a state, and to disapprove those rates if they do not meet statutory requirements.

Section 962 became effective on October 1, 1980. HCFA has announced, in interim guidelines, that state nursing home reimbursement methods approved before October 1, 1980 will be deemed to meet the provisions of the new law, unless a court has determined otherwise.

In the first survey, thirty-two states identified nursing home reimbursement as a major barrier to efficient program operations. One state, Delaware, noted that its nursing home expenditures in 1980 were more than expenditures for its entire Medicaid program in 1976. In the second survey, nursing home reimbursement was rated high, although not as high as in the first survey. This may reflect, on the one hand, states' optimism about the potential effect of the new law; and, on the other hand, continued concern that the implementing regulations should adequately address state problems.

Physician Reimbursement

Section 1902(a)(30) of the Social Security Act requires that Medicaid payments must not exceed reasonable charges consistent with efficiency, economy, and quality of care. Section 1903(i)(1) requires that payments not exceed certain Medicare reasonable charges determined according to Section 1842(b)(3).

Medicaid regulations at 42 CFR 447.341 apply two upper limits to payments to physicians and other individual practitioners. According to the first limit, Medicaid must not pay more than the lowest of:

- the physician's actual charge,
- the physician's reasonable charge under Medicare, or
- the physician's median charge for a given service.

According to the second limit in the regulation, Medicaid must not pay more than the higher of:

- the 75th percentile of the range of weighted customary charges in the same locality set under Medicare, or

- the prevailing reasonable charge under Medicare.

In the first survey, half of the states reported that these restrictions are too inflexible. Only two states reported that physician reimbursement requirements were not a problem. States reported that physician reimbursement levels were too low in many cases, for several reasons:

- Because the Medicare population is primarily elderly, some procedures are seldom used by Medicare recipients. The small sample size used to create the reasonable charge may distort fees. Fees that are too low can reduce the quality of care and the number of physicians willing to accept Medicaid.

- Regional variations in Medicare rates within a state must be followed by the Medicaid agency, despite what may be strong needs to increase rates in certain areas to encourage provider participation or to influence location decisions.

- Failure of Medicare carriers to keep fee schedules up to date, or their use of a system different from what the state uses (for example, RVS vs. CPT), can hinder a state's ability to keep fees current.

States believe that the current system stifles innovation and increases administrative complexity:

- States are limited in the ability to grant fee increases for physicians, to manage care for recipients who overutilize services, or to allow incentive payments for cost-effective practices that minimize institutionalization.

- Although fee schedules can be used under current requirements, development and negotiation of fees are complicated by the limits set by Medicare.

In addition, if the Medicaid agency negotiates a low rate with an individual practitioner, the provider is penalized for Medicaid participation because of methods used to develop the Medicare fee.

The report, Physician Pricing in California, confirmed that the Medicare method of determining reasonable charges contains an inherent inflationary incentive. The report recommended that it should be eliminated as a method to determine payments to physicians by Medicare and Medicaid. States find existing requirements do not allow them to pursue purchasing agreements that are adaptable to program objectives of accessibility and cost control.

Amount, Duration, and Scope/Comparability

Section 1902(a)(10)(B) requires that Medicaid services made available to any categorically needy individual must not be less in amount, duration, or scope than the services made available to any medically needy individual or to any other categorically needy individual. Section 1902(a)(10)(C)(ii) requires that Medicaid services made available to all medically needy individuals shall be equal in amount, duration, and scope.

Section 1902(a)(10) allows for certain exceptions to these comparability requirements, with respect to:

- skilled nursing facility services,
- EPSDT,
- family planning,
- institutions for tuberculosis,
- institutions for mental diseases,
- inpatient psychiatric services,
- Medicare benefits, and
- individuals who are receiving (or who could be receiving, if not in a medical institution) a state supplementary payment.

Another exception to the comparability requirements is provided in Section 1902(a)(23) for individuals receiving services under a Medicaid contract with a health care organization.

The comparability requirements are implemented in regulations in 42 CFR 440.230-440.250. In addition to the provisions of the law, these regulations require that:

- each Medicaid service provided be sufficient in amount, duration, and scope to reasonably achieve its purpose (440.230(b)); and

- states may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition (440.230(c)(1)).

In the telephone survey, twenty-six states reported that amount, duration, and scope requirements were a barrier. Not a single state felt that these requirements were not a problem.

A number of court decisions based on these laws and regulations have prevented states from making proposed changes in their Medicaid services.

Several states indicated that comparability provisions prevented them from adding services for the aged only, in order to defer or prevent institutionalization. Another state reported considering providing emergency dental services for recipients over age 21; however, this state feared that a broad interpretation of the sufficiency requirement could force it to cover all dental services, which it could not afford to do. In all these cases, the regulations blocked the addition of services.

States have also pointed out that the requirements have limited their ability to target services and to establish normative service standards on which payment can be based, measures that could be among the most effective and least harmful types of cutback. Under a waiver allowed by Section 1115 of the Social Security Act, the New Jersey Department of Health sets hospital rates for Medicaid and all other payers by establishing rates per case for diagnosis-related groups (DRG's). The DRG patient classification system categorizes patients into diagnostic groups that are similar in clinical attributes and use of hospital resources. Limitations of this type cannot be implemented without a waiver of current regulations.

Mandatory and Optional Services

The term "medical assistance" is defined in Section 1905(a) of the Social Security Act. Included in the definition is

a list of 18 numbered paragraphs containing the care and services that may be paid for under Medicaid.

Section 1902(a)(13)(B) requires states to provide categorically needy recipients the following services based on paragraphs (1) through (5) and (17) of Section 1905(a):

- inpatient hospital services,
- outpatient hospital services,
- rural health clinic services,
- laboratory and X-ray services,
- skilled nursing facility services,
- EPSDT,
- family planning services,
- physician services, and
- nurse-midwife services.

According to Section 1902(a)(13)(C), states with a medically needy program must provide medically needy recipients either:

- the services listed in paragraphs (1) through (5) and (17) of Section 1905(a), or
- the services listed in any seven of the paragraphs numbered (1) through (17) of Section 1905(a).

Section 1902(a)(13)(A)(ii) requires states to provide home health services for individuals entitled to skilled nursing facility services.

When the Medicaid program started, the law required states to provide five mandatory services. Since then, Congress has added home health, family planning, EDSDT, rural health clinic, and nurse-midwife services. Generally, the intent of these additions is to reduce costs by substituting preventive for acute and chronic care services, and by allowing the use of less expensive forms of care while establishing rational priorities for service. Requirements that state Medicaid programs move toward a comprehensive system of care were removed in the 1972 amendments to the Act.

Most of the requirements for mandatory services are implemented in regulations in 42 CFR 440.210 and 440.220. The home health requirement is in 441.15.

Seventeen states identified requirements that group some services as mandatory and others as optional as barriers to improved operations. There is no apparent substantial medical or economic basis for the current categorization of services. Further, the distinction seems to be related more to the type of provider than to the medical service provided.

Several states noted that many mandatory services were added by congressional action over the last ten years, and that states have limited ability to exert any control over the scope of mandatory services. West Virginia stated that it was paying more for rural health clinic services than for similar physician services. States must reimburse rural health clinic services, even though flexibility in reimbursement could enable them to increase payment to physicians in underserved areas and thereby improve access to care.

Maryland complained that federal regulatory interpretation did not allow the exclusion of any service provided in an out-patient hospital setting, even if that service is not otherwise covered under the State Plan. This enables hospitals to determine what services are provided, and limits state control over new services offered in hospital based settings, such as dental services or psychiatric day treatment. States believe they need greater latitude to define the array of available services.

Statewideness

Section 1902(a)(91) requires a Medicaid State Plan to be in effect in all political subdivisions of the state. Section 1902(a)(23) provides that a state shall not be held to be out of compliance with Section 1902(a)(1) because of services offered only under a contract with a health services organization, or because of services offered only by rural health clinics.

The requirement that a state plan be in operation in all political subdivisions is a carryover from earlier medical assistance programs. Early Medicaid provisions required a minimum level of state funds, to ensure that comparable services could be delivered statewide regardless of local funding available, and to prevent disproportionate burdens among localities.

Requirements and exceptions concerning statewideness are implemented in 42 CFR 431.50. According to 431.50(b), a Medicaid State Plan must be in operation statewide through a system of local offices, and the Medicaid agency must ensure that the plan operates continuously in all local offices or agencies.

In the survey, twelve states identified statewideness as a problem; seven states felt that statewideness is not a problem.

The states that saw statewideness as a barrier argued that it leaves states without the flexibility to address problems unique to a given geographic area. The availability of services, economic conditions of the medical marketplace, and needs of different groups are not uniform in any state. In large states, disparities can be significant.

One Medicaid director noted that in terms of medical need, statewideness can be as arbitrary as state boundaries. States cannot use different types of providers in different parts of the state. For example, New York City has a well-established network of public and voluntary mental health clinics. In other parts of the state, such clinics are not available, and private practicing psychologists provide mental health services. To use different types of providers by area to deliver essentially the same service violates statewideness requirements. A state is also prohibited from providing services to sub-state areas of need, such as concentrations of aged persons or refugees.

Pennsylvania felt that differences in service delivery between urban and rural areas need to be recognized.

Florida suggested that optional services should be selected at the county level, based on local priorities for service.

Early and Periodic Screening, Diagnosis, and Treatment

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was established by Congress in the 1967 Amendments to Title XIX. In the 1960s, the Selective Service discovered that more than 15 percent of eighteen-year-olds examined for military duty were rejected for medical reasons. However, it was estimated that more than 60 percent of the serious conditions were preventable or correctable. Disabling conditions and inadequate medical care are far more common in the poor than in other groups. Congress believed that early detection and treatment would reduce the amount and severity of medical problems among

the poor, and would provide long-term benefits by enabling people to lead productive, healthy lives. Section 1905(a)(4)(B) establishes the early and periodic screening and diagnosis of individuals under age 21 to ascertain their physical or mental defects, and provides for health care, treatment, and other measures to correct or ameliorate defects or chronic conditions discovered.

Because states were slow to implement EPSDT, Congress amended the law in 1972 to establish a penalty for the failure of a state to meet certain requirements. Section 403(g) establishes a penalty against federal funds for AFDC if a state fails to:

- inform families of the availability of child health screening services,

- provide or arrange for screening when requested, and

- arrange for the corrective treatment of problems discovered by screening.

The Department of Health and Human Services attempted to revise EPSDT regulations over a period of years. Notices of Proposed Rule Making were issued in 1975 and in 1977 before final EPSDT penalty regulations were released in 1979. These regulations, effective on October 1, 1979, were an attempt to increase state efforts to screen and treat children. However, the regulations have had the effect of making it more difficult and more costly for states to deliver health care to children by mandating many specific processes. In the first survey, more states identified EPSDT as an example of a federal regulatory barrier than any other issue.

The EPSDT Technical Advisory Group has submitted to the Office of Child Health in HCFA a comprehensive analysis of EPSDT from the state perspective. Examples of some of the more troublesome requirements are:

- Face-to-face informing. Families must be informed face-to-face within sixty days of eligibility determination. This precludes the use of cost-effective methods such as first making written or telephone contact, with face-to-face reserved for nonresponsive cases, and forces states to inform during intake, the least effective method.

- Timeframes for initiating treatment. Treatment must be initiated within a specific period for

problems discovered. This requirement does not consider the availability of specialists, the billing practices of providers, or the type or severity of the condition requiring treatment.

- Free choice of providers. Under the regulations, each of the nine components of the screening exam could be delivered by a different provider if the receipient so requested. This works against any simple, organized system of care, and increases cost of transportation, scheduling, assistance, and monitoring.

- Documentation. States are required to maintain records and produce lists solely for the purpose of penalty reviews. These have limited usefulness for service delivery activities but require extensive data collection and automated systems development.

- Direct referral to a dentist. States must refer all children over the age of three to a dentist. States are not allowed to establish reasonable criteria--such as dental screening of children ages three to five--before sending them to a dentist. States can be liable for penalties if the level of program participation by dentists is low.

States generally support the objective of providing preventive health services to children, and believe that services can be delivered more effectively without detailed and process-oriented federal requirements. Current EPSDT requirements seem to disregard other health services that children may be receiving in a state. Between them, the statutory penalty and the regulations can put a state at risk for attempting to serve certain difficult cases; consequently, avoiding the penalty rather than serving children has become the program's focus.

The EPSDT Technical Advisory Group has developed an "active plan" approach that involves the annual development of goals and objectives by a state. This approach directs state efforts toward outcomes rather than compliance with federally mandated processes. To implement the action plan approach, it is necessary to:

- Repeal Section 423(g) of the Social Security Act, which establishes the penalty.

- Amend Section 1902(a)(23) of the Social Security Act, which requires free choice of provider.

- Amend current EPSDT regulations, 42 CFR 441.50-441.90.

Utilization Control in Long-Term Care Facilities

Because of concern for the quality and appropriate use of long-term care services, Congress has instituted a number of requirements for the certification and review of these services. These utilization control requirements are implemented in regulations in 42 CFR 456.

Physician certification: According to Section 1903(g)(1)(A) of the Social Security Act, a physician must certify, and periodically recertify, the need for each recipient's receiving SNF and ICF services. This must be done at the time of admission and at least every sixty days thereafter. This physician certification requirement is implemented for SNF's at 42 CFR 456.260, and for ICF's at 42 CFR 456.360.

Plan of care: Section 1902(a)(26)(A) requires written plans of care in SNF's. Section 1902(a)(31)(A) requires a written plan of service prior to admission or authorization of benefits in an ICF. Section 1903(g)(1)(B) requires SNF and ICF services to be furnished under a plan established and periodically evaluated by a physician. These plan of care requirements are implemented for SNF's at 456.280, and for ICF's at 456.380. The regulations require a plan of care to be reviewed every sixty days for SNF services and every ninety days for ICF services.

Medical evaluation and admission review: Section 1902(a)(26)(A) requires a regular program of medical review and medical evaluation of each patient's need for SNF care. Section 1902(a)(31)(A) requires a regular program of independent professional review and medical evaluation of each patient's need for ICF care. Section 1903(g)(1)(C) requires a continuous program of utilization review whereby each SNF and ICF admission is reviewed or screened in accordance with criteria established by medical and other professional personnel. These medical evaluation and admission review requirements are implemented for SNF's at 456.270-456.271, and for ICF's at 456.370-456.371.

Inspections of care: Sections 1902(a)(26)(B) and (C) require periodic inspections and reports, by medical review teams, of the care being provided each recipient in SNF's. Sections 1902(a)(31)(B) and (c) require periodic on-site inspections and reports--by independent professional review teams--of the care being provided each recipient in ICF's. Section 1903(g)(1)(D) requires an effective program of medical review of the care of patients in SNF's and ICF's whereby the professional management of each case is evaluated at least annually by independent professional review teams. These requirements for inspections of care are implemented in 456 Subpart I.

Quarterly showing and penalty provisions: Section 1903(g)(1) requires that federal funds be reduced, by a specified formula, for any quarter in which a state fails to make a satisfactory showing that it has an effective program of utilization control for long-stay inpatient services. These quarterly showing and penalty provisions are implemented in 456 Subpart J.

State concerns about long-term care utilization control revolve around two major topics: requirements about the use of physicians, and the complexity or redundancy of other requirements.

In the telephone survey, seventeen states indicated that physician requirements were a problem. It is widely admitted that a system of paper compliance has been created. Physician certification and recertification must be accomplished according to a rigid timetable; if it is missed by one day, payment is jeopardized. In most areas, it is difficult to prescribe what physicians must do; in rural areas with physician shortages, difficulties arise because physician assistants may not be used to meet these requirements.

Fourteen states identified other long-term care utilization control issues as barriers. States believe that there is considerable duplication between inspection of care and facility survey activities, both of which are done annually. New York and other states suggested that states should have options to integrate these requirements, to vary the inspection cycles based on the quality of care in the facility, or to use sampling techniques to meet inspection of care requirements. States also suggested that the submission of a quarterly showing report had very little to do with quality of care, and

that the validation survey could be incorporated in regular state assessment procedures to save administrative costs.

The Wisconsin Department of Health is using an experimental system to improve medical and independent professional reviews under an 1115 waiver. The experimental system reviews a sample of patients intensively, rather than reviewing all patients. Full reviews are not conducted except where indicated by the sampling. The project also conducts facility surveys based on how well a facility has been performing.

Co-Payments

Section 1902(a)(14) of the Social Security Act permits states, within certain limits, to share some of the costs of Medicaid with recipients. The limits in law are as follows:

- No enrollment fee may be imposed on the categorically needy.
- Any enrollment fee imposed on a medically needy individual must be related to the individual's income.
- No co-payment may be required of the categorically needy for mandatory services.
- Any co-payment that is imposed on the categorically or medically needy must be nominal.

These provisions are implemented in 42 CFR 447.50-447.59. The regulations also add minimum and maximum income-related amounts for enrollment fees, and maximum amounts for charges such as co-payments and deductibles.

The Congressional Budget Office believes that federal Medicaid expenditures could be reduced by about $700 million in 1982 if recipients were required to share the costs of all Medicaid care they receive. The CBO pointed out that such a requirement might reduce the use of medical services not necessary for good health; but it could also cause the deferral of necessary or socially desirable care, with the result of higher treatment costs in the future.

In the survey, thirty-one states identified existing co-payment regulations as barriers to program efficiency. Most states believe that the maximum amounts allowed in

the regulations for cost-sharing are too low. The major problems states have with the requirement is the prohibition against co-payments for mandatory services by the categorically needy. Although a few states expressed interest in establishing nominal across-the-board co-payments, most wanted to use co-pay to modify the use of certain services and settings, and to apply co-pay differently by groups of eligibles. For example, one state suggested establishing fairly significant co-payment levels for certain inappropriate uses of emergency rooms or outpatient services. States believe that the current requirements are overly restrictive, and that recipients are too insulated from the consequences of their inappropriate use of certain services.

Professional Standards Review Organizations

The Social Security Amendments of 1972 established the Professional Standards Review Organization (PSRO) program in order to "promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made" under the Social Security Act. The PSRO program attempts to meet this goal by means of a peer review system. The primary emphasis of the program has been to reduce the use of hospital care by means of concurrent reviews of hospital admissions and continued care.

The statutory basis for the PSRO program is Title XI, Part B (Sections 1151 through 1173) of the Social Security Act.

Section 1155 describes the duties and functions of a PSRO. Section 1155(e) permits PSRO's to delegate reviews to hospital review committees that demonstrate their ability to carry out review functions effectively and promptly.

Section 1158 requires approval by a PSRO as a condition for the payment of certain claims. Section 1158(a) prohibits the use of federal funds for a Medicaid service if the service is subject to review by a PSRO and the PSRO has disapproved the service. According to 1158(c) when a PSRO has been found competent by the secretary of HHS to review specified health care services, the PSRO's reviews of those services will be binding, and will replace Medicaid state agency reviews.

The regulations for the PSRO program are in 42 CFR Subchapter D; 42 CFR 466 concerns PSRO hospital review; and the rules for delegated review are in 466 Subpart C.

The conclusive effect of PSRO determinations on claims payment is covered in 42 CFR 463 Subpart B. According to 42 CFR 463.27, PSRO review activities shall be in lieu of the corresponding review activities required under Medicaid.

There have been several evaluations of the PSRO program. Studies conducted by the Congressional Budget Office concluded that PSRO review of Medicare patients lowers short-term hospital stays somewhat, but that the effect of PSRO review on Medicaid hospital use is unclear. Although PSRO's do save the federal government some money, overall costs to society exceed savings.

In the telephone survey, sixteen states identified problems related to the use of PSRO's. In the second survey, seven states identified PSRO's as one of the most important barriers to efficient Medicaid program operations; seven other states, however, reported that PSRO's are not a problem.

Several states reported dramatic increases in admissions, lengths of stay, and hospital days per thousand eligibles after PSRO's assumed hospital review responsibilities. One state reported apparent shifts of SNF payment responsibilities from Medicare to Medicaid after the PSRO began reviewing nursing homes. Another state was not allowed to establish a prior authorization system for hospital services as a cost control measure, because that was supposed to be a PSRO responsibility. Some states have had to abandon parts of existing monitoring systems. Many states simply do not have the leverage with PSRO's to ensure compatibility with state cost containment goals.

Medicaid Quality Control

The Title XIX basis for the Medicaid quality control system is Section 1902(a)(4), which requires such methods of administration as the secretary of HHS may find necessary for the proper and efficient operation of the Medicaid State Plan. More specific quality control goals have been included in some appropriation measures.

The Medicaid quality control regulations are in 42 CFR 431 Subpart P. The quality control program they require is intended to reduce erroneous expenditures by monitoring:

- eligibility determinations,

- third-party liability activities, and
- claims processing.

The quality control system involves case samples, review, reports, and corrective action steps. As part of the required corrective action, a Medicaid agency must correct any error found in a sample case (42 CFR 431.800(g)).

On January 25, 1980, HCFA added Section 431.802 to Subpart P, which requires states to reduce their payment error rates, in equal steps, to 4 percent by September 30, 1982. States that do not reach their target error rates are subject to a reduction in federal funding. Section 431.802 implemented the continuing resolution for FY 80 (P.L. 96-123).

Twenty-one states said that problems in quality control requirements are barriers to more efficient program operations. Quality control has caused difficulties between state and federal officials for some time. In general, states believe that quality control efforts are important, but that the current requirements are based on the false assumption that state mismanagement is at the heart of program problems. Because quality control overstates the amount of funds that can be recovered, it reinforces the negative public image of Medicaid. Many states said that the regression formula used to calculate error rates is inadequate, and that it weights certain factors inappropriately.

North Carolina stated that some quality control requirements are trivial but tremendously burdensome, such as photocopying entire case files for federal review. North Dakota said that at one point they spent $6,000 to resolve a $1,000 problem. Several states noted that the complexity of quality control instructions and processes is made worse by frequent changes in instructions. Wisconsin stated that other monitoring tools are available to review third-party liability and claims processing, and that quality control should focus on eligibility. Several states found that quality control is used to check on policy compliance, although policies are in the State Plan and quality control is supposed to be used only to monitor how these policies are executed.

Health Maintenance Organizations

Health maintenance organizations (HMO's) are legal entities that provide specific comprehensive health care services to voluntarily enrolled members in return for a prepaid

fixed payment. According to their proponents, HMO's offer an efficient alternative to the traditional fee-for-service health care system. The federal government has assisted the growth and development of HMO's since passage of the Health Maintenance Organization Act of 1973.

Because of the freedom of choice provisions in Title XIX, Medicaid recipients are in principle free to receive their health care from an HMO or other prepaid health plan if they so choose. According to Section 1902(a)(23) of the Social Security Act, recipients may obtain Medicaid services from any qualified provider, "including an organization which provides such services, or arranges for their availability, on a prepayment basis..." In practice, a state Medicaid agency must first contract with an HMO before the HMO choice becomes available to recipients.

Section 1903(m) of the Social Security Act defines the term "health maintenance organization" for Medicaid purposes. Section 1903(M) also sets certain conditions on payments to states for HMO services. According to Section 1903(m)(2)(A), Medicaid payments may not be made to an HMO if half or more of the membership of the HMO consists of individuals who are Medicare Part B beneficiaries or Medicaid recipients.

Section 1903(k) authorizes the secretary of HHS to provide technical and actuarial assistance to any state that wants to contract with an HMO.

The regulations covering Medicaid contracts with HMO's are in 43 CFR 431 Subpart L. The 50 percent limit on Medicare and Medicaid eligibles is found in Section 431.528. (Section 431.569 applies the same 50 percent limit to contracts with prepaid health plans that are not HMO's.)

In the first survey, twelve states identified current HMO requirements as barriers. Most felt that the 50 percent limit is a barrier and should be removed. Maryland suggested easing existing restrictions on the confidentiality of information, so that eligibility lists could be used to improve the marketing of HMO's. Florida and other states suggested that eligibility extensions should be provided to recipients who enroll in HMO's, or that recipients should share in savings from their enrollment. California felt that federally qualified HMO's should be required to have a Medi-Cal contract.

Sterilization Requirements

Sterilizations and hysterectomies are not mentioned in Title XIX of the Social Security Act. When they are medically necessary, however, they are covered under Medicaid hospital and physician services.

In March 1979, the U.S. District Court in Washington, D.C. decided that no federal funds could be used for sterilizations unless the patient is legally of age, competent, and has given informed consent. These requirements, among others, were implemented by the Department of Health, Education, and Welfare in April, 1979.

In 1978, the Health Care Financing Administration (HCFA) issued the current regulations pertaining to sterilizations and hysterectomies. These regulations, in 42 CFR 441 Subpart F, include the following requirements:

- A hysterectomy cannot be performed solely for the purpose of sterilizing the patient.
- The person securing authorization to perform the hysterectomy must inform the patient, orally and in writing, that the operation will make her sterile.
- The patient must sign a statement acknowledging that she was informed the operation would make her sterile.

No exceptions to these requirements are allowed.

Appended to Subpart F is a lengthy consent form that must be used unless a substitute form has been approved by the secretary of HHS.

On January 18, 1981, HCFA proposed to eliminate the acknowledgement requirement in certain situations, for example if the patient is already sterile or if an emergency exists. The proposed rule would not otherwise change or simplify the Subpart F requirements.

In the telephone survey, twenty-four states said that the existing requirements are barriers to efficient program operations. In the follow-up survey, sterilization was not ranked as high; this change probably reflects that survey's bias toward high fiscal impact priorities, and the recognition that HCFA is making an attempt to relieve states of some of the requirements. Even with the proposed changes, no states indicated that the requirements are not barriers.

Indiana reported that the requirements are one of its biggest headaches; yet the service was one of the smallest expenditures in the program. Wisconsin indicated that it did not claim any federal dollars for sterilizations because the federal requirements were too extensive.

The intent of the federal policy is to ensure that sterilization services are received voluntarily, and that no one is sterilized without full knowledge or against one's will. States recognize the need to protect all citizens against abuse and believe that Medicaid recipients should be given the same protection as everyone else; but they argue that the present regulations are too detailed.

States are concerned about the consent form itself, the time requirements, and the need for special administrative monitoring of requirements:

- There are eighteen blanks on the form which must be filled out. Many entries are repetitious: the doctor's name must be entered three times, the type of operation four times, the patient's name four times.

- If a woman applies for and becomes eligible for Medicaid after the hysterectomy procedure is performed, no FFP is available because forms were not completed before the procedure, even though FFP is available for other Medicaid services the woman may have received during the same period.

- States must monitor the accuracy and completeness of the forms, because of the rigid federal review system. Rhode Island estimated that it spends approximately $15,000 for administrative monitoring each year.

In addition, Medicaid requirements must be met even though Medicare has approved the claim and the state is responsible only for co-payments and deductibles.

The effect of the regulations and their emphasis on the enforcement of process has been negative. Wyoming reported that several indigent patients were sued for hysterectomy costs the state could not pay for under the regulations. Many states say that the requirements have adversely affected their relationships with physicians and hospitals.

Eligibility Complexity

Medicaid eligibility policies are lengthy and complex. A number of subsections and paragraphs in different parts of

Title XIX affect eligibility for Medicaid. The regulations for Medicaid eligibility in the states and in the District of Columbia are in 42 CFR 435; eligibility in Guam, Puerto Rico, and the Virgin Islands is covered in 42 CFR 436.

Section 1902(a) (10) of the Social Security Act establishes required and optional coverage groups; states must cover categorically needy recipients of cash assistance. States may also choose to cover medically needy individuals who have too much income for cash assistance but not enough for medical care.

Section 1902(f) allows states to restrict Medicaid eligibility for aged, blind, or disabled individuals to those who would have been eligible under the Medicaid State Plan in effect on January 1, 1972. This provision was added by Section 209(b) of P.L. 92-603.

States that choose to cover the medically needy, and states that restrict eligibility under the 209(b) option, are required by law to deduct incurred medical expenses from applicants' incomes in determining Medicaid eligibility. Individuals in these states are therefore able to "spend down" their income by incurring medical expenses to the point where they qualify for Medicaid.

The spenddown requirements for the medically needy are implemented in 42 CFR 435 Subpart I. Spenddown requirements for 209 (b) states are in 42 CFR 435.735. States are required to determine:

- covered medical expenses,
- incurred medical expenses,
- levels of protected income, and
- budgeting periods,

In the telephone survey, eleven states reported that spenddown requirements are a barrier to efficiency.

Another reason why Medicaid eligibility policies are complex is that many groups were given grandfathered eligibility when changes were made in Social Security or cash assistance programs. For example, Section 1902 (a) of the Social Security Act continues Medicaid eligibility for individuals who would be eligible except for the 20 percent; and the Social Security increase in 1972 P.L. 92-603, which created the Supplemental Security Income (SSI) program effective in 1974,

requires continued Medicaid coverage for those who were eligible in December 1973 as:

- essential persons,
- institutionalized individuals, and
- blind or disabled individuals.

When Congress instituted Social Security cost-of-living increases in 1977, it also required continued Medicaid coverage for individuals who became ineligible for cash assistance as a result of those increases.

These grandfathering requirements are implemented in regulations at 42 CFR 435.112 and 435.121 through 435.135. Six states reported that grandfathering requirements are a problem.

In addition to the grandfathered groups, the law provides two other eligibility extensions. Section 1902(a) (34) requires retroactive coverage for individuals who received medical care (and would have been eligible for Medicaid had they applied) during the three months preceding their application. Section 1902(e) requires four months' continued Medicaid eligibility for families who become ineligible for AFDC because of increased employment hours or income.

The three-months prior requirement is implemented in 42 CFR 435.914, and the four-months post requirement in 42 CFR 435.112. Ten states identified problems in extension of eligibility requirements.

Another group of complex regulations governs what relatives may and may not be asked to contribute toward the cost of medical care. The financial responsibility of relatives is, in effect, limited because of SSI policy and court decisions. (Regulations about relatives responsibility for the categorically needy are found in 42 CFR 435 Subpart H, and for the medically needy in 42 CFR 435 Subpart I.) During the telephone survey, eleven states identified these requirements as barriers to more efficient program operations.

A report submitted to HCFA in 1977, entitled Comprehensive Review of Medicaid Eligibility, found that eligibility policies are even more complex than cash assistance policies, and that they are indeed so complex or unworkable that many states modify or ignore numerous federal policies.

The telephone survey results show clearly that eligibility policies continue to be a source of many problems and frustrations to states.

B. Cross-Cutting Concerns

States believe that many specific federal requirements act as barriers to efficient operations. In addition to these, several broader themes emerge that seem to underlie many specific problems. These "cross-cutting" concerns are:

- prudent buying of services;
- process orientation of requirements;
- federal presence;
- service targeting;
- external factors;
- institutional bias.

Prudent Buying of Services

Survey issues: free choice of providers, hospital reimbursement, nursing home reimbursement, co-payments, physician reimbursement, family supplementation, claims payment, incentives for recipients, rural health clinic reimbursement, and maximum allowable cost.

Building the prudent-buyer concept into the Medicaid program is the most significant change that can be made to improve program efficiency. States believe that the current system lacks incentives for economy. Statutes and regulations block states from acting as prudent buyers; there is limited control over what services are bought, where they are bought, how they are bought, how much is paid, and in what manner payment is made. Recipients and providers are insulated from the consequences of the cost of using services, and demand is not moderated by market constraints. There are no adequate incentives and controls to encourage recipients to act as prudent buyers.

Process Orientation of Requirements

Survey issues: EPSDT, sterilization requirements, quality control, spenddown, eligibility complexity, notice of change in methods or levels of reimbursement, duration of ICF and SNF

agreements, ICF-MR standards, MCAC, advance planning requirements, explanation of benefits.

Requirements that focus on processes can obscure the objectives of the program; resources are allocated to means rather than to ends. In some cases, processes mandated for specific programs may not fit state needs; EPSDT and sterilization requirements are good examples. Process orientation hinders the introduction of innovations in state programs, innovations that other states could learn from and adapt to their programs. It leads to overly-rigid program structures; especially when processes are established by law, as in long-term care utilization control requirements.

The cumulative effect of process requirements can be great, although individual requirements, by themselves, may not seem substantial. States identified a number of requirements that delay the implementation of program changes. For any change, states may have to:

- consult with a Medical Care Advisory Committee, although many meet only on a quarterly basis;
- provide public notice of changes in the method or level of reimbursement sisty days before the changes are implemented;
- submit changes in the State Plan to the regional office of HCFA for approval;
- meet federal advance planning requirements for purchases of automatic data processing equipment;
- notify recipients ten days before any termination, reduction, or suspension of services, and offer a fair hearing.

These requirements are in addition to state actions that may be necessary to implement changes, such as obtaining legislative approval, developing automated systems, developing policy guidelines, training staff, informing providers, meeting state Administrative Practices Act requirements, and publishing and distributing manuals and forms. The general effect is the slowing of a state's ability to implement changes and the reduction of overall flexibility.

Federal Presence

Survey issues: state plan responsiveness, state assessments and reviews, quality control, long term care utilization control.

In the surveys, states raised many issues about the sheer weight of federal involvement in the program; in particular, they questioned the usefulness of, and the lack of coordination among, the many federal reviews. Reviews include state assessments, quality control reviews, MMIS certification and system performance reviews, and validation reviews.

Several states reported problems with the timing of annual assessments. New Jersey said it was not opposed to assessments, but believed they should be held less often than annually. One state pointed out that it received results from the previous year's survey at about the time the next survey began; this left no time to implement corrective action.

The time that must be spent on various federal reviews can be considerable. Iowa estimated that it had federal officials in its offices for seven to nine weeks each year. Nevada reported fifteen federal visits in one year, despite a low rate of quality control errors. States noted that claims processing was reviewed in state assessments, quality control, and system performance review activities. Some states questioned the usefulness of findings, which often discovered issues states already knew existed or believed were not in urgent need of change. Several states complained about the federal lack of understanding of the realities of running state programs, and felt that despite the volume of reviews there was little good technical assistance.

Service Targeting

Survey issues: amount, duration, and scope/comparability; mandatory and optional services; statewideness; medical necessity.

Existing statutes and regulations do not allow the flexibility to develop and move to a new mix of services, or to target service delivery according to need. The requirements establish a basic level of Medicaid service that is available throughout the state, and prohibit any discrimination against localities, population groups, or people with specific problems. In principle, these guarantees are important; they recognize the national commitment of access to a basic level of health care. In practice, they have limited

state abilities to adjust to changing situations and different needs. States find it difficult to make incremental shifts in program coverage. The simplest form of cutback management under the regulations is the complete elimination of optional services and groups from the program.

External Factors

Survey issues: hospital reimbursement, physician reimbursement, eligibility complexity, PSRO's, Medicare/Medicaid coordination, bed restrictions, Indian Health Services, Medicaid coverage of Medicare Part B Services, definition of medical necessity, rate of FFP.

There are some factors beyond the scope of the Medicaid program that do, in practice, affect program operations. In the survey, states addressed issues that diminish their ability to set program boundaries that help them establish and maintain fiscal integrity. The Medicaid program has been given or has assumed certain responsibilities; but it has also been tied to factors beyond its control. These factors can intensify the essential dilemma of a Medicaid administrator: how to reconcile a closed state budget system with open-ended demands on Medicaid resources.

Foremost among external factors is the relationship between Medicaid and Medicare reimbursement policies. Medicare influences Medicaid because of the relative share of expenditures by each program, and because specific limits to Medicaid reimbursement are established according to Medicare policies.

There are many other examples of how actions in one program affect the other:

- Medicaid pays Medicare premiums, coinsurance, and deductibles for Medicaid eligibles who are covered under a buy-in agreement. Because many providers do not accept assignments from Medicare, and because Medicare provides services that may not be covered under a State Plan, Medicaid pays for more services to certain groups than it provides to other Medicaid eligibles.

- To the extent that federal policies discourage the participation of nursing homes in Medicare, and as long as federal policy does not require participation

in both programs, Medicaid will bear costs for serving Medicare-eligible recipients who choose homes participating only in Medicaid.

States feel limited in their ability to define what services are medically necessary. States believe that Congress intended to prohibit payment for services that were not medically necessary. However, court decisions have expanded this definition requiring states to pay for virtually any service a physician orders regardless of state coverage limitations.

States are limited in utilization control because PSRO's have assumed control activities that used to be the responsibility of the states. In acute hospital settings, PSRO's can delegate review authority to the hospital; neither the PSRO nor the state can override binding authority once it has been delegated. Many states reported major losses of program control and increased expenditures because of PSRO activities.

States have weak authority over reimbursement, aspects of service coverage, and utilization control, all major components of the Medicaid program. States lack control because program requirements do not delegate authority to states; not because states are hesitant to take control.

Institutional Bias*

Survey issues: free choice of providers; nursing home reimbursement; amount, duration and scope/comparability; mandatory and optional services; statewideness; family supplementation; provider participation; bed restrictions; home health; medical necessity.

Although institutional bias was a survey issue, it is also a cross-cutting issue connected with a number of others. Seventeen states identified institutional bias as a barrier in the first survey. In the second survey, fourteen states reported that institutional bias is a significant barrier; only one state reported that it was not a problem.

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* Long Term Care: Background and Future Directions (Health Care Financing Administration, 1981) provides an excellent discussion of many long-term problems, including the institutional bias of Medicaid.

The Comptroller General's November 1979 study on Entering a Nursing Home--Costly Implications for Medicaid and the Elderly reported that:

- Medicaid's long-term care support goes primarily to institutional care rather than to in-home or community-based services;

- Difficulties in obtaining community-based long-term care lead to admissions that might have been avoided;

- Medicaid's assessment and placement mechanisms do not prevent such avoidable institutionalization.

Several eligibility factors increase the Medicaid bias toward institutional care. Medicaid coverage may be reduced or unavailable if a person lives with or receives support from family or friends. The financial responsibility of families is limited, however, when the person enters a nursing home. In states not covering the medically needy, many individuals are eligible for Medicaid only if they are in a nursing home; thus, they are eligible for nursing home care but not for community care. In addition, states cannot control private-pay patients who enter a nursing home and then deplete their resources, thereby becoming eligible for Medicaid.

States have not had as much control as they would like over their institutional programs. The reasonable cost-related reimbursement system and the free choice of provider requirement have limited a state's ability to control the proportion of its Medicaid budget spent on nursing home care. State Medicaid agencies have also had little ability to limit the number of institutional beds they will support under Medicaid. This is important, because there is a linear relationship between bed supply and bed use: it seems that if beds are available, they will be used. States that do not already have adequate community care programs now face difficulties in increasing their alternate care. Comparability and statewideness requirements limit a state's ability to target services to those at risk of institutionalization. Optional services that could help complete a community care program may be cut back or not offered at all, because mandatory services exhaust the available funds.

That alternatives to institutionalization have not increased more quickly under Medicaid is due in part

to medical necessity requirements. Confusion about the concept of "medical necessity" has weakened some states' ability to plan and manage their services. Courts have relied on the concept to enforce certain benefit expansions. At the same time, some states have been hesitant to expand community-based Medicaid services that would help individuals retain their independence, because they fear that such services would be found not "medically necessary."

C. Changing Federal Regulations

This study identified barriers to efficient Medicaid program operations in federal statutes, reporting requirements, and regulations. Issues identified tend to be those that impose either significant financial or significant administrative burdens. The highest-ranked issues in the survey tend to have high financial costs; these issues are primarily based on statutory requirements. Issues that have been created by regulations, on the other hand, tend to be administrative ones that consume unwarranted amounts of staff time and attention.

Table IV-A* classifies each issue as either a statutory or a regulatory barrier. Issues were listed as statutory barriers if changes in the law are needed for their solution; if regulatory or administrative changes could solve the problem, issues were listed as regulatory barriers. Table IV-A is of necessity an oversimplification, because there is often a complex relationship between an issue and various laws, judicial decisions, regulations, and administrative actions. Some of the issues classified as requiring statutory changes could be at least partially solved by regulatory changes. But even with these caveats, the number of issues which require statutory changes is impressive.

Although definition of sepcific solution is beyond the scope of this project, states did provide comments for solutions and improvements to the existing requirements.**

Because many of the most costly requirements were created by statute, congressional action is necessary before states can make many program changes necessary for improved efficiency. However, a number of regulatory changes could be initiated promptly by HCFA, and

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* Table IV-A appears on page 61.
** See Appendix E.

Table IV-A

Issues Classified as Barriers in Statute or Regulation

Statute	Regulation	
	x	EPSDT
x		Free Choice of Providers
x		Hospital Reimbursement
	x	Nursing Home Reimbursement
x		Co-Payments
x		Amount, Duration and Scope/Comparability
x		Physician Reimbursement
	x	Sterilization and Hysterectomy Requirements
	x	Quality Control
x		Mandatory and Optional Services
x		LTC Utilization Control (Physician)
x		Institutional Bias
x		PSRO's
x		Utilization Control in Nursing Homes (General)
x		Health Maintenance Organizations
x		Third-Party Liability
x		Statewideness
	x	Spenddown
x		Eligibility Complexity
x		Family Supplementation
	x	Institutions for Mental Disease (IMD's)
x		Eligibility Extensions
	x	State Plan Responsiveness
	x	State Assessments and Reviews
x		Recipient Suspension
x		Medicaid/Medicare Coordination (SNF)
	x	Notice of Changes in Reimbursement Levels
x		Eligibility Grandfathering
	x	Reporting Requirements
x		Provider Participation
	x	Duration of SNF and ICF Agreements
	x	Assurance of Transportation
	x	ICF-MR
x		Claims Payment
	x	Medical Care Advisory Committee
x		Home Health
	x	Limitations on Medicaid Coverage of Part B Services
x		Indian Health Services
	x	Residency Requirements
	x	Advance Planning Requirements
x		Incentives for Recipients
x		Medicaid--IV-D Coordination
	x	Maximum Allowable Cost
	x	Institutionalized Individuals--Start Date for FFP
x		Definition of Medical Necessity
x		Rural Health Clinic Reimbursement
x		EOMB. (Utilization Control)
x		Rate of FFP
x		Chiropractic Services

would demonstrate commitment to removing federal barriers:

- EPSDT regulations should be repealed and replaced by the action planning approach suggested by the EPSDT Technical Advisory Group.

- Sterilization regulations should be repealed and replaced by state requirements that protect against abuses.

- Requirements to publish notice of change in the level or method of reimbursement should be repealed.

- Nursing home reimbursement regulations will need to be changed because of recent changes in the law. The new regulations should be written to allow states the flexibility intended by Congress.

- The reclassification of nursing homes as institutions for mental disease should be stopped.

- Requirements for Medical Care Advisory Committees should be repealed.

Regulatory changes can be made in other areas as well. Most of these will require additional state input to develop reasonable solutions. Based on survey results, the priorities for joint state and federal efforts to remove regulatory or administrative barriers are:

- Quality control

- Eligibility issues (especially spenddown)

- State assessments and reviews

- ICF-MR requirements.

There are Technical Advisory Groups for quality control and eligibility. Creating additional Technical Advisory Groups, allocating more resources, and accelerating work and meeting schedules can produce the necessary results.

In 1979, HHS created the Office of Health Regulations to study current health regulations and recommend the elimination of those that are unnecessary. The office

discovered that "many officials expected us to identify regulations for elimination, but no one could identify even one specific example. It speedily became apparent that there is a constituency for every rule."*

They found that not enough attention is paid to policy and cost benefit analysis of HHS regulations and decisions to regulate, and that upper-level management oversight of decisions to regulate needs to be improved. The report suggested, "If there is no body of knowledge to support positively a regulatory intervention by the Department, there should be no such intervention until such knowledge and information becomes available."**

Several states pointed to flaws in the regulatory process that, they believe, must be corrected to ensure that future regulations will be less problem-ridden. They were heartened by several recent attempts to improve the regulatory process, e.g., Executive Orders 12044, 12174, and 12291.***

Regulations must largely rely on a system of voluntary compliance to be successful. Active advance consultation about decisions to regulate, and alternatives to regulation, need to be developed. The project advisory

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* U.S. Department of Health and Human Services, Office of Health Regulations, The Reform of Regulations in the Department of Health and Human Services: Proposals for Change (Washington, D.C.: Government Printing Office, 1981).

** Ibid.

***Executive Order 12044 requires federal agencies to review their existing regulations periodically.

Executive Order 12174 establishes procedures to reduce paperwork burdens and requires periodic review of forms and requests for information.

Executive Order 12291 provides that no major regulations can be proposed or issued by federal agencies without review by the Office of Management and Budget to ensure that the measure is necessary and takes the lowest-cost approach.

committee noted that the semi-annual agenda of regulations published in the Federal Register is helpful for planning, but it is not clear how states could get priorities and needs on the agenda. The length of the existing agenda seems to indicate that HCFA has few idle resources that could be used to address state concerns.

D. Cost Impacts of Requirements

A number of states developed estimates of the cost impact of certain federal requirements, the potential savings from changing these requirements, and other potential savings in the program. This section summarizes, and extracts from, material developed by states at the request of this project. Some of the options are in the proposal state; others are being further developed by states. Therefore, the options listed should be viewed as what might be done, not necessarily as what will be done.*

Issue: Free Choice of Provider

California is exploring the feasibility of becoming a more prudent buyer of hospital services by limiting Medi-Cal participation to those facilities whose costs are not excessive. Alternative approaches being considered include:

- determining hospital reimbursement on a prospective basis;
- contracting only with the lowest-cost hospitals in each area for the provision of Medi-Cal services; and
- reimbursing for selected services in approved regional centers only.

The first of these alternatives--prospective reimbursement--offers the greatest potential for immediate implementation. Under this system, rates would be adjusted for each hospital's expected case mix and for differences in patient volume.

The hospital would be at risk for the cost of services. If the cost of services provided exceeds the prospective rate, the hospital would absorb the deficit; conversely,

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* Appendix D contains the material sent to states as a resource in developing estimates.

if the cost of services were less than the prospective rate, the hospital would retain the excess or the state may establish a basis for sharing savings.

To the extent possible, billing, reporting, and payment procedures would be simplified to reduce administrative costs for hospitals and for the state.

The system offers advantages to a hospital, because administrative costs would be lower and cash flow would be improved. In exchange, a hospital would have to accept reasonable payment from the state, bear some risk for fluctuations in volume and expenses, and be committed to controlling costs.

The state would save because the prospective system gives hospitals an incentive to use the most effective methods of treatment. Hospitals would benefit from simplification of billing and reporting. California estimates that annual savings could be between one to ten percent of total Medi-Cal costs, or between $10 million and $100 million in state and federal funds.

California pointed out that any alternative to limit hospital participation has a number of possible problems. Care must be taken to:

- ensure access to emergency services;
- ensure access to all medical specialties;
- maintain physician-patient relationships and hospital privileges;
- ensure access in rural areas;
- maintain county hospitals' participation in Medi-Cal.

California is considering contracting prospectively with selected laboratories for all non-emergency lab tests. This would reduce the number of laboratories providing non-emergency services from 1,000 to between 15 and 20.

Medi-Cal now spends $35.8 million per year on laboratory services. Audits and other evidence suggest there have been overuse of and overpayments for many lab tests. The large number of laboratories participating in the program makes utilization and quality control difficult.

Most physicans do not do their own lab work if it is extensive; they send it to central laboratories. There have been scandals because of rebate schemes.

The benefits from restricting freedom of choice and contracting with a limited number of laboratories include:

- lower unit costs with high volumes and improved economies of scale;
- better quality of laboratory tests, through more effective controls; fewer misdiagnoses on Medi-Cal patients;
- lower administrative costs to the state and laboratories;
- faster turnaround.

California estimates that savings of up to 30 percent of expenditures on lab services--or $10.7 million--are possible in the first year of prospective contracting.

Volume purchasing of drugs and appliance such as hearing aids and eyeglasses can also provide substantial savings in California. For drugs, the state would contract with manufacturers for a rebate determined by the volume of the drug used. Drug selection by pharmacists would be limited to the brand and price established by the state. For appliances, the state would use competitive bidding to purchase eyeglass frames, lenses, and hearing aids in bulk, and would supply the materials through selected distributors. The state would pay only a professional fee to the distributors.

California believes that a volume purchasing system can improve utilization controls and product quality. In the first year, the savings in drug expenditures could amount to $14 million; the savings in appliances could be $5.5 million.

Georgia feels it would benefit from changes in free choice of provider requirements, especially with regard to inpatient hospital services. The state does not believe that restricting the participation of physicians whose costs are excessive would be equitable or would produce savings, because the state recently implemented a fee schedule for physician services.

Georgia would define "excessive cost providers" in the inpatient hospital services as "those providers whose cost per case exceeds 130 percent of the mean of their peer groups." Georgia has been granted a waiver by HHS to implement an alternative hospital reimbursement system. This system groups hospitals according to their physical and service characteristics and contains incentives and penalty provisions for providers whose case costs fall below or above a certain percentage of the mean for their group.

An implementation impact study produced an estimate of a $1 million reduction in payments to hospitals during the first year of the waiver. This reduction results from fiscal penalties incurred by hospitals whose case costs exceed 130 percent of mean for their group. Georgia believes that additional savings would be possible by restricting participation of hospitals exceeding 130 percent of the mean. However, participation can only be restricted in geographic areas where an adequate number of participating facilities remain to serve the caseload previously served by the excluded providers. If providers of special services were excluded, the availability of these special services from "unaffected" providers would have to be considered before a final decision to restrict could be made.

Georgia also estimates it could save $5.9 million per year by mandating HMO enrollment of recipients who live in the seven-county metropolitan Atlanta area, if they could negotiate contracts at 95 percent of fee-for-service costs for those recipients. (Based on FY 80 unduplicated recipient counts and average cost per recipient.)

Issue: Service Targeting

Cost estimates based on modifications to statewideness were not received in time to be included in the final report. Kansas provided information about possible savings from restricting coverage for certain diagnoses. Assuming that the number of recipients served and the cost per patient day remain constant, Kansas' annual savings could amount to $3,991,632.* Kansas believes the services are available in less expensive settings.

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* Table IV-B shows the rates of use, and the costs for certain services with coverage restrictions based on diagnosis.

Table IV-B

Possible Limitations in Coverage
by Diagnosis in Kansas

PSYCHIATRIC INPATIENT HOSPITAL STAYS			
CURRENT		PROPOSED	
Length of stay	21 days	Length of stay	14 days
Recipients served	3,453	Recipients served	3,453
Total days	72,513	Total days	48,342
Total cost	$9,281,664	Total cost	$6,187,776

ALCOHOL/DRUG TREATMENT INPATIENT HOSPITAL			
CURRENT		PROPOSED	
Length of stay	30 days	Length of stay	10 days
Recipients served	388	Recipients served	388
Total days	11,640	Total days	3,880
Total cost	$1,222,200	Total cost	$407,400

Issue: PSRO's

Michigan provided information about change in the number of hospital admissions and the average length-of-stay that have occurred since PSRO's began reviewing in-patient hospital services. Before that, Michigan manually reviewed all inpatient claims that exceeded the 75th percentile of length-of-stay criteria. After review of appropriate documentation, Michigan disallowed any days identified as not medically necessary, and adjusted the claim. The last full year this method was used was 1977; the administrative costs for that year were $132,872.

In 1978, Michigan began using the PSRO's to review the medical necessity of hospital admissions and length-of-stay, as required by federal regulation. For about one year, the stake monitored a 20 percent sample of the PSRO review results; after that, once it felt assured that PSRO review was functioning effectively, it stopped the sample monitoring. Administrative costs for monitoring the sample were $265,269 for the year.* Should PSRO reviews be discontinued, Michigan would reinstate its previous monitoring system; the state expects that this would reduce lengths-of-stay.

Table IV-C

Hospital Lengths of Stay in Michigan Medicaid Program

	1977	1978*	1979	1980
Number of Days	469,357	492,836	497,730	531,562
Average Length of Stay	5.90	6.23	6.29	6.26

* First year of PSRO review.

Issue: Hospital Reimbursement

In Illinois, hospitals account for about 55 percent of the Medicaid spending. Hospitals in Illinois are not subject to statewide rate regulation; they are paid 100 percent of allowable reasonable costs, following Medicare principles for all inpatient and outpatient Medicaid days.

The state believes the current reimbursement method contains a perverse incentive for increasing costs, but federal approval of alternative systems is difficult to obtain. The state would like to see reform of Medicaid requirements

* Table IV-C shows the increases in lengths of stay in Michigan since PSRO reviews began.

to allow more options. If requirements change, Illinois would consider establishing a maximum inpatient hospital per-diem payment of $400. This would reduce Medicaid's subsidization of physicians' education in large, expensive teaching hospitals.*

Table IV-D

Potential Savings from Change in Hospital Reimbursement Method in Illinois for FY 1982

	Without Change	With Change
Recipients Served	958,000	958,000
Utilization (days)	2.1742	2.1742
Average Per Diem	$ 318.11	$ 306.45
Total Cost	$ 662.6 million	$ 638.3 million
Total Savings		$ 24.3 million

New York State has been working on issues of hospital cost containment for several years. Between 1974 and 1978, the state estimates it saved $2.3 billion in Medicaid hospital care costs by taking certain measures, such as decertifying and reclassifying unnecessary hospital beds; requiring certain uncomplicated procedures to be performed in an outpatient setting; eliminating Medicaid coverage for Friday and Saturday admissions, except for emergency care; and using third-party health insurance for Medicaid eligibles.

The total Medicaid budget for New York will be an estimated $4.6 billion in 1981-82, with inpatient hospital expenditures of $1.4 billion, 30 percent of the total budget.

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* Table IV-D shows possible savings should this method be used for FY 82. The table does not include administrative expenses; however, the state does not expect any appreciable increase in that area.

Problems in the existing system for inpatient hospital reimbursement in New York occur because it uses cost-based methods that encourage unnecessarily expensive care, and because different payers use different reimbursement systems. Medicaid and Blue Cross pay on the basis of average costs in a prospective reimbursement system. Medicare sets rates in a retrospective system, using the ratio of costs to charges. This complicates administration; besides, because Medicaid and Blue Cross pay on the basis of average costs but Medicare pays below-average costs, there is a built-in shortfall to hospitals.

A state Council on Health Care Financing recently recommended creating a uniform mechanism for financing general hospital inpatient care. The proposal applies Medicaid's cost containment measures to Medicare; it puts all major payers on a single prospective payment system, and establishes an inpatient revenue cap for each hospital, based on peer groupings adjustable for certain factors such as inflation or changes in mix or volume of services.

The proposal will not result in any savings for Medicaid in FY82. In fact, an increase of 4.25 percent is expected in the first year; this should drop to 2.25 percent in the second year and .25 percent in the third year. However, New York believes the proposal will bring long-range benefits such as:

- a decline in rates-of-cost increases, to approximately the inflation factor; this should slow the growth of the base from which prospective rates will be calculated;

- a guaranteed revenue cap, which should create incentives to reduce unnecessary use of services.

Issue: Co-Payments

Kentucky suggests requiring co-payment of $5.00 by the categorically eligible and the medically needy for non-emergency visits to hospital emergency rooms. Based on a 1979 study by the Kentucky Medical Assistance Program, about 25 percent of all emergency room visits are inappropriate. The co-payment would reduce the hospital outpatient expenditure budget by 3.9 percent; $454,261 would come from decreased use, and $176,265 from the co-payment. An estimated $20,000 in administrative costs would be required to set criteria for coverage, make computer changes, and monitor outpatient claims for

inappropriate emergency room visits.

Kentucky also argues that a co-payment of $1.00 should be placed on excess physician office visits by all eligible recipients. "Excess" could be defined as more than three visits per month per individual. Extenuating circumstances, such as chronic illness or referrals made by the family physician, could be considered in defining whether visits are excessive. Data are not yet available to determine how many visits would fall into the "excessive" category.

A co-payment of $1.00 on all outpatient visits would produce about $1.4 million annually, and could have a deterrent effect as high as 10 or $1.6 million. Total program expenditures in Kentucky are projected to be $374 million for FY81.

New Jersey is considering a number of proposals to implement co-payments on certain services. In FY80, Medicaid payments were about $707 million. The New Jersey proposal would exclude EPSDT, long-term care, and services covered by Medicare, from co-payments.*

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* Table IV-E shows the possible savings from co-payment, excluding administrative costs and savings from change in use.

Table IV-E

Estimated Cost Savings Associated with Copayment
for Certain Services in New Jersey

Service	Estimated Number of Claims (1)	Projected Copayment	State/Federal Savings (2)
Transportation (3)			
Ambulance	9,759	$3.00	$ 29,277
Invalid Coach	286,239	1.00	286,239
Podiatry (3)	723,703	.50	42,722
Dental (3)	182,226	3.00	546,679
Optical Appliances	64,627	2.00	129,255
Pharmacy	5,698,369	.50	2,849,184

Service	Number Authorized	Projected Copayment	State/Federal Savings
Orthopedic Shoes (3)	4874	$2.00	$ 9,748
Hearing Aides (3)	1962	3.00	5,886
		TOTAL:	$3,898,990

(1) Based on 1980 Utilization data.

(2) Savings based on estimated number of claims. However, a claim may include more than one date of service.

(3) Includes EPSDT, Long-Term Care and Medicare related calims (where appropriate).

V. CONCLUSION

The major objective of this study was to identify federal regulations, statutes, and reporting requirements state Medicaid administrators perceive as barriers to efficient Medicaid operations.

Project staff obtained information about barriers by several means: a telephone interview with state Medicaid directors and other administrators; a written survey to determine agreement with a preliminary list of issues, and to determine how many states were affected by the barriers identified; and feedback from a presentation of preliminary findings at the annual state Medicaid directors' meeting. After the first survey, project staff asked some states to develop cost estimates of reforms in requirements for free choice, hospital reimbursement, co-payments, PSRO's, and scope of services.

Although this study was broad and covered statutes, regulations, and reporting requirements, it had certain limitations. First, the project was conducted in a very short time--less than three months--so that results could be presented at the annual meeting. Primary data were gathered by telephone, a method which carries some risk of error. Although project staff contacted all states with Medicaid programs, there was no attempt to study individual programs in depth, or to focus on states with larger shares of the Medicaid budget.

Second, as the study began, the Reagan administration announced its proposal to cap Medicaid expenditures. This study does not examine the political constraints on solutions to problems, or what input and effect the provider community will have on possible program changes.

Third, this project--because its objective was to identify problems--does not focus on federal requirements the states consider to be good because they moderate provider or consumer demands. Nor does the project highlight successes in the federal and state Medicaid partnership.

Clearly, there is much need for additional research into Medicaid.

The findings of this study reveal that states place high priority on relief from many federal requirements. Both the response rate and the level of responding staff were high, indicating a keen interest in the topic.

In the telephone survey, states identified forty-nine issues

as barriers; five of these were identified by thirty or more states, and twenty-four were identified by ten or more states. The number and distribution of issues demonstrates that states are concerned about many areas of Medicaid; the problems they see are not narrowly focused on a small number of federal requirements.

The second survey shows that many of the issues are seen as barriers by many states, even though they might not have ranked among the top ten or fifteen priorities. States tended to rank highest those issues where they believe reforms could bring substantial cost savings; these top issues also tended to require statutory--rather than merely regulatory--change. These highest-ranking issues included requirements for free choice of provider; hospital, nursing home, and physician reimbursement; statewideness; amount, duration, and scope; and mandatory and optional services. Issues for which regulatory reform can be significant without statutory change include EPSDT, quality control, sterilization requirements, and eligibility issues. Reporting requirements were mentioned as issues; however, states saw these usually as part of a broader regulatory or statutory problem, such as EPSDT or nursing home utilization control requirements.

This project was based on the assumption that federal requirements create inefficiencies, and that inefficiencies cost money. The study found that little is known about the exact costs of requirement-created problems; analyses of the costs of regulations and decisions to regulate have not been adequate so far. States may need to allocate more resources to cost analysis, if they are to argue more effectively for specific changes in federal requirements.

HCFA, too, needs to allocate sufficient resources to cost and policy analyses of regulations, to hasten the repeal of unnecessary requirements and to ensure that future requirements are as effective as possible.

It has been said that the current regulations have a good deal of flexibility, if states would only learn to use that flexibility better. State administrators, however, do not perceive much flexibility; and their perception shapes state behavior. If the perception is inaccurate, there is at the very least a need to improve the quality and quantity of technical assistance to states. Technical assistance should increase even as resources shrink, because the options for and the effects of changes need to be researched, and because states will need training as policies changes and new techniques are introduced. Besides, a more flexible system with more state diversity of program operations will no doubt require more resources to support exchange of information and

learning among states, and to enhance state planning.

Although individual requirements may appear to allow states some latitude, the cumulative effect of the various requirements restricts state options. Requirements determine what a state can do, and how quickly it can respond. States point to significant cross-cutting concerns that reveal how interrelated the effects of regulations can be. These broad concerns included states' inability to act as prudent buyers of services; the unnecessary details and process orientation of many requirements; states' inability to reallocate resources and make incremental shifts in coverage to improve effectiveness; the loss of Medicaid management control to other federal programs such as Medicare and PSRO's; and Medicaid's institutional bias.

States want flexibility in requirements to be made permanent by statutory action whenever possible. States also believe that flexibility must be granted as soon as possible, to minimize adverse effects of potential cutbacks. As a complementary action, the waiver authority of HCFA should be broadened to allow waivers of any Medicaid program requirements that are not demonstrably cost effective, and that do not support the service delivery objectives of an individual state. The waiver authority now available under Section 1115 should be used as liberally as possible; many states believe the current use of 1115 waiver authority is too restricted.

Given the number and diversity of state programs, it is not surprising that specific national solutions to problems are not always apparent. Indeed, if they were, it would be far easier to solve problems through federal regulations. States consistently stressed the desire for flexibility, so that they can take innovative and varied approaches to Medicaid administration; obviously, not all states will use flexibility the same way.

As for HCFA, it will need to rethink now its efforts to support state management activities, and it needs to decide how mutual state and federal objectives can be reached. The broad challenge is to seek national solutions to problems in delivering quality health care services under Medicaid in many diverse--but related--state initiatives and activities.

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Appendix A

Checklist of Issues, First Survey

After each state provided a list of issues, the interviewer reviewed the checklist and asked if there were issues in any of the following areas not mentioned by the respondent. The checklist was developed from previous surveys and records of the American Public Welfare Association and the National Governors' Association.

Statewideness

- greater flexibility to provide different services in sub-state regions.

Mandatory/Optional Services

- greater flexibility to define services convered under the program.

Coverage by Diagnosis

- ability to limit or extend coverage based on diagnosis.

Cost Sharing

- extension of co-payments to selected procedures in mandatory services for the categorically needy;
- establishment of reasonable cost sharing by relatives of institutionalized clients.

Free Choice

- ability to restrict participation of providers with excessive costs;
- increased use of competitive bidding and negotiation;
- matching of recipients to providers.

Reimbursement

- flexibility to establish rates consistent with budgetary constraints.

Utilization Control

- continued use of PSRO's.

Quality Control

Eligibility

- institutional bias of policies;
- difficulty in administering spenddown.

Long-term Care

EPSDT

HMO's

- elimination of the 50 percent rule.

Medicare Coordination

Appendix B

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Appendix C

Regulations and Statutes Identified in First Survey, By Issue

Issue	Regulation	Social Security Act
1. EPSDT	42 CFR 441 Subpart B	Section 1905(a)(4)(B) - includes EPSDT as a Medicaid service Section 403(g) - specifies conditions under which HHS will impose a penalty on states
2. Free Choice Providers	42 CFR 431.51	Section 1902(a)(23) - provides that recipients may obtain services from any qualified provider
3. Hospital Reimbursement	42 CFR 447.261	Section 1902(a)(13)(D) - requires that states pay the reasonable cost of inpatient hospital services
4. Nursing Home Reimbursement	42 CFR 447.272 - 447.316	Section 1902(a)(13)(E) - provides that states must pay skilled nursing and intermediate care facilities on a reasonable cost related basis NOTE: This section was amended by Section 962 of P.L. 96-499, "Omnibus Reconciliation Act of 1980."

Issue	Regulation	Social Security Act
5. Co-Payments	42 CFR 447.53 - 447.56	Section 1902(a)(14) - provides that co-payments cannot be imposed on the categorically needy for mandatory services.
6. Amount, Duration, and Scope/Comparability	42 CFR 440.230 - 440.250	Section 1902(a)(10) - establishes comparability of services for groups of recipients.
7. Physician Reimbursement	42 CFR 447.341	Section 1902(a)(30) - provides that payments cannot exceed reasonable charges consistent with efficiency, economy, and quality of care. Section 1903(i)(1) - requires that payments not exceed certain Medicare reasonable charges Section 1903(i)(1) - provides that payments cannot exceed certain Medicare reasonable charges determined according to Section 1842 (b)(3).
8. Sterilizations	42 CFR Part 441 Subpart F	Section 1902(a)(4) - provides for establishment of methods of administration necessary for the proper and efficient operation of the State Plan.
9. Quality Control	42 CFR Part 431 Subpart P	Section 1902(a)(4) - provides for establishment of methods of administration necessary for the proper and efficient operation of the State Plan.

Issue	Regulation	Social Security Act
10. Mandatory and Optional	42 CFR 440.210, 440.220	Section 1905(a) - establishes services available under Title XIX. Section 1902(a)(13)(B) and (C) - prescribes required care and services.
11. Longterm Care and Utilization Control - Physician Responsibilities	42 CFR 456.260, 456.360	Section 1903(g)(1)(A) - requires physician certification of the need for services.
	42 CFR 456.280, 456.380	Section 1903(g)(1(B) - requires that services be furnished according to a plan.
12. Institutional Bias	42 CFR 440.70, 440.170 42 CFR 435.231	Section 1905(a) - establishes services available under Title XIX. Section 1902(a)(10) - allows coverage of individuals in institutions as optional categorical eligibles. See also 20. Family Supplementation
13. PSRO's	42 CFR Subchapter D	Title XI, Part B - establishes the PSRO program

Issue	Regulation	Social Security Act
14. Utilization Control in Nursing Homes - General	42 CFR 456 Subpart E, F, I, and J	Section 1902(a)(30) - requires that the State Plan provide methods to guard against unnecessary utilization. Section 1902(a)(26)(A) - establishes a program of medical review in SNF's. Section 1902(a)(31)(A) - establishes a program of independent professional reviews for ICF's. Section 1902(a)(26)(B) and (C), and 1902(a)(31)(B) and (C) - requires inspections of care and services in institutions.
15. Health Maintenance Organizations	42 CFR 431.528, 431.569	Section 1903(m) - limits membership to no more than 50 percent Medicare and Medicaid eligibles.
16. Third-Party Liability	42 CFR 433 Subpart D	Section 1902(a)(25) - requires states to pursue third-party liability. Section 1912 - allows assignment of rights as a condition of eligibility.
17. Statewideness	42 CFR 431.50	Section 1902(a)(1) - requires a State Plan to be effective throughout the state.
18. Spenddown	42 CFR 435 Subpart I	Section 1902(a)(17) - requires reasonable standards for the determination of eligibility.

Issue	Regulation	Social Security Act
19. Eligibility Complexity	42 CFR Part 435 See also: 18. Spenddown 19. Family Supplementation 22. Eligibility Extensions 28. Eligibility Grandfathering	Section 1902(a)(10) - establishes required and optional coverage groups. Section 1902(f) - allows restrictions to eligibility for the aged, blind, or disabled.
20. Family Supplementation	42 CFR 435.712, 435.723, 435.733, 435.734	Section 1902(a)(17) - requires reasonable standards for determination of eligibility. Section 1902(f) - allows states to use their own more strict eligibility standards than those established for SSI.
21. Institutions for Mental Disease	42 CFR 440.250	Section 1905(a) - establishes services available under Title XIX.
22. Eligibility Extensions	42 CFR 435.112	Section 1902(e) - establishes four-month continued eligibility for families ineligible because of increased hours or income from employment. Section 1902(a)(34) - establishes three-month retroactive eligibility.
23. State Plan Responsiveness		Section 1902(a) - establishes requirements for State Plans for medical assistance.

Issue	Regulation	Social Security Act
24. State Assessments and Reviews		Section 1902(g)(2) - authorizes the secretary to conduct validation reviews of the appropriateness and quality of institutional services. Section 1903(4)(4)(A) - requires regular reviews of MMIS system. Section 1904 - authorizes the secretary to review administration of the State Plan and to withhold payments for non-compliance.
25. Recipient Suspension	42 CFR 455.22	Section 1909 - establishes federal penalties for fraudulent acts.
26. Medicare/Medicaid Coordination - SNF		Section 919 of P.L. 96-400 (Omnibus Reconciliation Act of 1980) - requires a study of the effect of requiring dual participation of all SNF's.
27. Notice of Change in Method or Level of Reimbursement	42 CFR 447.205	Section 1902(a)(30) - requires that payments for service not exceed reasonable charges consistent with efficiency, economy, and quality of care.

Issue	Regulation	Social Security Act
28. Eligibility Grandfathering	42 CFR 435.114, 435.131 - 435.135	Section 1902(a) - continues Medicaid eligibility for individuals who received Social Security increases (P.L. 92-336). Section 1905(k) - limits effect of added income for an essential person (P.L. 93-66).
29. Reporting Requirements		Section 1902(a)(b) - requires states to comply with reporting requirements. Section 1903(d) - requires states to make quarterly estimates of expenditures. Section 1903(g) - requires reporting of a valid showing of utilization review activities.
30. Provider Participation	42 CFR 431.51, 42 CFR 447.35	Section 1902(a)(23) - provides that recipients may obtain services from any qualified Medicaid provider. Section 1122 - limits FFP for expenses related to certain capital expenditures.
31. Duration of ICF and SNF Agreements	42 CFR 442.15	Section 1902(a)(27) - requires provider agreements. Section 1910(c) - allows judicial review of termination decisions.

Issue	Regulation	Social Security Act
32. Assurance of Transportation	42 CFR 431.53, 42 CFR 440.170	Section 1902(a)(4) - provides for establishment of methods of administration necessary for proper and efficient operations. Section 1905(a) - establishes services available under Title XIX.
33. ICF-MR	42 CFR 442 Subpart G	Sections 1905(c) and (d) - give the secretary authority to prescribe standards for intermediate care facilities for the mentally retarded.
34. Claims Payment	42 CFR 447.45	Section 1902(a)(37) - establishes time standards for the payment of claims.
35. Medical Care Advisory Committee	42 CFR 431.12	Section 1902(a)(4) - provides for establishment methods of administration necessary for proper and efficient operations.
36. Home Health	42 CFR 440.70	Section 1905(a) - establishes services available under Title XIX.
37. Limitations on Medicaid Coverage of Part B	42 CFR 431.625	Section 1843(a) - enables states to enroll certain recipients under Medicare Part B. Section 1902(a)(10)(C)(ii)(II) - allows exceptions to comparability for Part B enrollees. Section 1903(a)(1) and 1903(b) - establishes 100 percent FFP for Indian Health Services.

Issue	Regulation	Social Security Act
38. Indian Health Services	42 CFR 431.110	Section 1911 - makes Indian Health Service facilities eligible for reimbursement under Medicaid. Section 1905(b) - establishes 100 percent FFP for Indian Health Services.
39. Residency Requirements	42 CFR 435.403	Section 1902(a)(16) - allows the secretary to make rules for coverage of residents absent from a state.
40. Advance Planning Requirements	45 CFR 95 Subpart F	
41. Incentives for Recipients		
42. Medicaid/IV-D Coordination	42 CFR 433.151 - 433.154	Section 1912(a)(2) - provides for cooperative arrangements to obtain medical support through child support agency.
43. Maximum Allowable Costs	42 CFR 447.331	Section 1902(a)(30) - requires that payments for service not exceed reasonable charges consistent with efficiency, economy, and quality of care.

Issue		Regulation	Social Security Act
44.	Coverage of Institutionalized Individuals	42 CFR 435.722(c)	
45.	Definition of Medical Necessity		
46.	Rural Health Clinic Reimbursement	42 CFR 447.371	Section 1902(a)(13)(F) - provides for reasonable cost-related reimbursement
47.	EOMB	42 CFR 456.22	Section 1902(a)(30) - provides for procedures relating to the utilization of care and services.
48.	Rate of FFP	42 CFR 433 Subpart A	Section 1905(b) - establishes the method for calculating the federal medical assistance percentage.
49.	Chropractic Services	42 CFR 440.60	Section 1905(g) - defines services a chiropractor may perform.

Appendix D

Cost Estimate Request

Selected states were asked to provide cost estimates for the following issues:

Free Choice of Providers/Prudent Buyer

1) Restrict or eliminate participation by providers whose costs are excessive. Indicate which services could be affected, what other provider characteristics are necessary (for example, restrict providers only in areas of provider surplus), and how "excessive" could be defined (for example, in the current array of providers costs, which would be considered excessive?).

2) Use competitive bidding and negotiation for lab services, or other standardized products. Identify the services or products to which competitive bidding and negotiation could be applied.

3) When an efficient organized health system or HMO is available, limit free choice by requiring enrollment, unless the recipient chooses not to enroll because of an existing relationship with a provider. Assume the 50 percent Medicare/Medicaid enrollment restriction is lifted. Estimate the extent to which HMO's could be used for this, the number of recipients enrollable, and then the potential savings (include any additional costs due to necessary eligibility extensions or enrollment guarantees.)

Service Targeting

1) Allow limitations on mandatory services when less expensive alternative settings are available. Identify services which can be replaced by less expensive alternatives or delivered in less expensive settings. Assume statewideness can be waived so that this substitution can occur regionally. Consider the relative share of eligibles, services, or rates of use in the area where each alternative can be used to the state as a whole.

2) Establish coverage limits based on diagnosis or condition. Identify conditions for which this limitation would be useful. Consider the relative share of eligibles, services, or rate of use where coverage limited by diagnosis can be used.

3) Allow exceptions to statewideness to use local resources to provide matching funds for additional services in sub-state areas and to allow states to target services to areas of need.

Professional Standards Review Organizations.

Describe any cost impacts directly attributable to PSRO activities. Estimate the cost impact for the state to reassume any utilization control functions now performed to PSRO's, including state administrative costs and resulting changes in the use of services.

Hospital Reimbursement.

1) Estimate hospital expenditures for FY 82 in total dollars and as a percentage of total state Medicaid expenditures. Use existing reimbursement system; assume no major changes in service coverage or eligibility.

2) Briefly describe the alternative reimbursement system which might be used, how it would be administered, and major differences between it and the current hospital reimbursement system.

3) Estimate hospital expenditures for FY 82 in total dollars using the alternative reimbursement system and compute the differences.

Co-Payments.

1) Identify the services and eligibility groups for which co-payment is administratively feasible.

2) Estimate the cost impact on services assuming full implementation for FY 82. Indicate the amount of the co-payment, the impact on service utilization, and the basis for assumptions about the relationship between co-payment amounts and service utilization.

3) If co-payment is used more selectively, identify procedures, services, or eligibles for which co-payment would be required, and estimate the cost impact.

Appendix E

Summary of State Suggestions for Reform of Major Problems

Free Choice

- Allow states broad authority in purchasing hospital and other institutional services, clinic services, laboratory services, and medical services.

- Allow competitive bidding and negotiation for standardized services or products.

- Restrict or eliminate participation by providers whose costs are excessive.

- Establish a case manager system of delivering care: a physician selected by the client would be responsible for managing total health care, until such time as the client freely chooses another case manager.

- Allow free choice at the time of eligibility determination but restrict coverage to the provider chosen.

Hospital Reimbursement

- Establish reimbursements "reasonable and adequate to meet the costs of efficiently and economically operated facilities" for hospital services.

  Remove the limitation on the number, currently six, of state hospital costs containment programs which may cover Medicare payments, and allow states to share in the Medicare savings attributable to the state efforts.

- Allow states to make adjustments in reimbursement rates based on budgeting constraints.

- Waive the provision of the Omnibus Reconciliation Act of 1980 that establishes payment rates for administratively necessary days when a state has a more effective system.

Nursing Home Reimbursement

- Write regulations implementing the recent law change giving states the authority and flexibility intended by Congress.

- Give states greater authority to limit the number of nursing home beds supported by Medicaid payments.

- Establish appropriate responsibility of families for financial support of institutionalized relatives.

Physician Reimbursement

- Abolish the current inflationary method of determining physician fees in Medicare.

- Eliminate the Medicare payment limits for Medicaid service.

- Allow incentive payments for cost-effective practices.

- Allow payment for managing health services for recipient.

- Allow Medicaid to correct urban-rural disparities.

Amount, Duration, and Scope/Comparability

- Allow limits on mandatory services when a less expensive alternative setting is available.

- Allow states to limit services based on diagnosis or condition.

- Write a statutory definition of medical necessity that improves state control over what services are available.

Mandatory and Optional Services

- Give states greater flexibility to define what services are available.

- Allow states to limit the availability of certain services or procedures available in mandatory service settings.

Statewideness

- Allow states to deliver some services only in specific parts of a state with special needs.

- Allow political subdivisions of the state to choose to provide additional services; match local funds with federal funds.

- Allow states to determine the appropriate type of provider to deliver certain services within different regions of the state.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- Eliminate the regulatory emphasis on administrative processes.

- Waive EPSDT requirements when comprehensive care provider assumes responsibility for the provision of care.

- Implement a state action plan requirement as suggested by the EPSDT TAG.

- Eliminate the EPSDT penalty against AFDC funds; use penalty provision of State Plan monitoring.

- Incorporate federal EPSDT monitoring into regular state assessments.

- Limit requirements to make additional services available that are not covered under the State Plan, especially orthodontia.

Utilization Control in Long-Term Care Facilities

- Allow states to develop alternatives to certification, recertification, and plan of care requirements in keeping with the state Medical Practices Act, individual patient need, and the quality of patient care available at the facility.

- Allow states to integrate facility survey and inspection of care requirements.

- Use sampling techniques to meet inspection of care requirements.

- Vary inspection cycles based on the demonstrated quality of care in the facility.

- Incorporate federal oversight of utilization control into the state assessment process.

Co-Payments

- Increase the amount of maximum allowable co-payments.

- Allow co-payment on any services or eligibility groups to discourage the unnecessary use of services and use of services in inappropriate settings.

Professional Standards Review Organizations

- Re-establish state authority for Medicaid utilization control.

- Allow states to contract with PSRO's for review if appropriate.

Medicaid Quality Control

- Restructure the regression formula used to calculate error rates.

- Develop a more accurate definition of errors.

- Focus quality control efforts on eligibility; use other review mechanisms for third party liability and claims processing.

- Limit recovery efforts to those that are cost-effective.

- Use the Technical Advisory Group to improve quality control policies.

Sterilization Requirements

- Simplify existing requirements and forms.

- Allow use of state systems to protect against abuses.

Eligibility Complexity

- Use the Technical Advisory Group to resolve problems in eligibility policy.

- Improve coordination of policies and processes between Social Secuirity Administration and Medicaid.

- Eliminate, or make optional with states, eligibility extensions and grandfathered groups.

Health Maintenance Organizations (HMO's)

- Waive 50 percent Medicaid/Medicare population limits.

- Require federally qualified HMO's to participate in Medicaid.

- Allow extensions of eligibility, sharing of savings, and other mechanisms for encouraging recipient enrollment in HMO's.

Appendix F

Number of Federal Regulatory Issuances Related to Medicaid, by Year*

1979	1980	
31	25	Proposed Rules Federal Register
35	27	Final Rules Federal Register
48	18	Notices Federal Register
112	93	HCFA Action Transmittals
42	37	HCFA Information Memoranda
65	63	Regional Medical Services Letters
31	41	Regional Health Standards and Quality Letters

* as reported by one state.

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